PORTREE MEDICAL CENTRE

HOW TO REGISTER WITH PORTREE MEDICAL CENTRE

Up to 6 years old

Please complete the enclosed forms:
'Application to Register Permanently with a General Medical Practice'
'New Patient Questionnaire'

All boxes marked with * must be completed

CHECKLIST

- ☐ Have you completed and signed the '*Application to Register Permanently with a General Medical Practice*' form?
- ☐ Have you completed the '*New Patient Questionnaire*'?
- ☐ Have you signed the consent to share contact details, if needed, on behalf of your child?
- ☐ If not for a newborn baby, please bring in the 'Red Book' to enable us to photocopy the record of vaccinations.
- ☐ If your child takes regular medication, you need to make an appointment with a GP before you can reorder it.
- ☐ For all newborns - please bring the form you were given by the registration office when you registered the baby.

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NEW PATIENT QUESTIONNAIRE
CHILDREN UP TO 6 YEARS OLD
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Has your child ever been seen at Portree Medical Centre before? Yes ◯ No ◯

Name ..... Date of Birth .....

Birth or Other Surname .....

Master ☐ Miss ☐ Other:

Do you give permission for contact details to be shared, when necessary, with others involved in your child's care? Yes ◯ No ◯

Signature ..... Date .....

Next of kin (name, address and telephone number) _____

_____

_____

Relationship _____

If new baby – mother's full name.....

Ethnicity – We hope that you do not mind completing this section. There may be cultural issues in relation to healthcare that we should be aware of.

I would describe my child's ethnicity as:

White Scottish ☐	Indian ☐	African ☐	Other ☐
White British ☐	Pakistani ☐	Black or Black Scottish ☐	
White Irish ☐	Bangladeshi ☐	Other Asian ☐	
Other White ☐	Chinese ☐	Any mixed background ☐	
	Caribbean ☐	Other ethnic group ☐	

Country of Birth:

UK ☐ Other EEC ☐ Other (Please specify): .....

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Personal Health History

Please list any illness the child has

Heart Disease	Yes ◯ No ◯	Stroke / CVA	Yes ◯ No ◯
Diabetes	Yes ◯ No ◯	High Blood Pressure	Yes ◯ No ◯
Asthma	Yes ◯ No ◯		

Please tell us about current conditions, past illnesses, accidents, operations or other hospital admissions including, if possible, a date or what age your child was.	
Illness/condition/accident/operation/admission etc.	Date/age
.....	.....
.....	.....
.....	.....

Medication

Please list all medication that your child takes. Please include any medication which is bought from the chemist.	
Name and dose	Name and dose
.....	.....
.....	.....
Does your child have any allergies? Yes ◯ No ◯	
Which, if any?	

Family History

Do either of the child's parents have or have had?

Heart disease	Yes ◯	No ◯	Mum ◯	Dad ◯
Diabetes	Yes ◯	No ◯	Mum ◯	Dad ◯
Stroke/CVA	Yes ◯	No ◯	Mum ◯	Dad ◯
Asthma	Yes ◯	No ◯	Mum ◯	Dad ◯
High blood pressure	Yes ◯	No ◯	Mum ◯	Dad ◯