**BRAEHEAD MEDICAL PRACTICE**

**BABY (FIRST) REGISTRATION QUESTIONNAIRE**

**Please complete all section of this questionnaire accurately**

Surname: ..................................... First Name(s): .................................. Date of Birth: ..............................

Address: ...................................................... \*Mobile and/or home Tel Contact No: ……………………………………

Previous Address: …………………………………………………………………….………... Previous GP: ………………………………….

……………………………………………………………………………………………………………………………………………..…………………

**\*PLEASE PROVIDE US WITH A MOBILE CONTACT NUMBER FOR THE PARENT/GUARDIAN OF THE CHILD**

Parent / Guardian name and address:

…………………………………………………………………………………………………………………………………………………………………

Name of previous Health Visitor (if applicable)

…………………………………………………………………………………………………………………………………………………………………

Is the Parent/Guardian registered or applying to register with Braehead Medical Practice: Yes / No

If ‘NO’ where is the Parent/Guardian currently registered: …………………………………………………….………………………

Is your child taking any regular prescribed medication ? YES / NO

If YES, details of prescription and condition:

………………………………………………………………………………………………………………………………………………………………….

Is your child allergic to any medication or substance? YES / NO

If YES, please give details:

**ETHNIC MONITORING**

Please state which Ethnic Group your child belongs to: ……………………………………………………….

Is there any other information about your child you think we should be aware of?

………………………………………………………………………………………………………………………………………………………………….

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**PLEASE ENSURE THE PRACTICE HAS A COPY OF THE REGISTRATION OF BIRTH FROM THE DISTRICT REGISTRAR**