Whitevale Medical Group

NHS Greater Glasgow and Clyde

NEW PATIENT (CHILD) QUESTIONNAIRE

Child's Name:			
Date of Birth		**Age:**	
Place of Birth:			**MALE / FEMALE**
Mother's Name:			
Mother's Contact No:			
Other Parent / Adult in the house:			

SIBLINGS	**Age**

School:			
Ethnic Origin:			
First Language			
Do you need an interpreter?	**YES**	**NO**	

Involvement of other agencies:

Any known illnesses, medication or allergies: