WESTWAY Medical Centre

Caring for the whole family

Westway, Maghull, L31 0DJ

Tel: 0151-526 1121
Fax: 0151-295 8552

SSCCG.N84025@nhs.net
westwaymcmaghull.nhs.uk

NEW PATIENT (CHILD) APPLICATION (up to age 16)

NAME ………………………………. **DoB …………………….……………**

PARENT ……………………….….. **ETHNIC ORIGIN ……………………...**

ADDRESS…………………………… **TEL………………………………………**

……………………………………………

……………………………………………

ILLNESSES – does he/she have any medical conditions or special problems

…………………………………………………………………………………….…

……………………………………………………………………………………….

HOSPITALS – has he/she been seen in clinic or had tests or operations at hospital?

……………………………………………………………………………………….

……………………………………………………………………………………….

ALLERGIES - is he/she allergic to any medicines/dressings/foods etc.

………………………………………………………………………………………..

IMMUNISATIONS – please list dates given

Vaccination	1st	2nd	3rd	Pre-School	15 years
Triple – Diphtheria, Tetanus, Whooping cough					
Polio					
Hib – Haemophilus Influenza					
MMR – Measles, Mumps and Rubella					
Meningitis C					
BCG Tuberculosis					

Ethnic Origin

Please indicate your ethnic origin. This is not compulsory, but may help with your healthcare, as some health problems are more common in specific communities, and knowing your origins may help with the early identification of some of these conditions.

Choose ONE section from A to E, and then tick ONE box to indicate your background.

A White

	British
	Irish
	Any other white background, please state:

B Mixed

	White and Black Caribbean
	White and Black African
	White and Asian
	Any other mixed background, please state:

C Asian or Asian British

	Indian
	Pakistani
	Bangladeshi
	Any other Asian background, please state:

D Black or Black British

	Caribbean
	African
	Any other black background, please state:

E Chinese or other ethnic group

	Chinese
	Any other, please state:

First language

Medication

Please give details of any medication which you take (prescribed or otherwise):

Name of drug: ……………………………………

Dosage: …………………………………………….

Name of drug: ……………………………………

Dosage: …………………………………………….

Name of drug: ……………………………………

Dosage: …………………………………………….

Nominated Chemist of your choice……………………………………

Lifestyle

Do you smoke YES / NO (please circle) if YES, how many ……../per day
if ex-smoker, when did you quit

DISABILITY

Please advise us if you have any specific information or communication needs-

…………………………………………………………………………………….

…………………………………………………………………………………….