

**Huthwaite Medical Practice      New Born Questionnaire**

<b>Personal Details</b>			
Full Name		Date of Birth	
Previous Name		NHS Number	
Address		Sex	<input type="checkbox"/> Male <input type="checkbox"/> Female
Postcode			
Telephone Number	(Home) (Mobile)		
<b>Consent for Text Messaging Service</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No

<b>Birth Certificate presented and name verified (Must be presented to enable registration)</b>		<input type="checkbox"/> Yes	<input type="checkbox"/> No
Ethnic Group (please tick)	<input type="checkbox"/> British or mixed British	<input type="checkbox"/> Other (please state)	
	<input type="checkbox"/> White Irish		
	<input type="checkbox"/> White other ethnic group		
	<input type="checkbox"/> Asian other ethnic group	Language (please state main language spoken)	
	<input type="checkbox"/> Black other ethnic group		

**Next of Kin or Carer Details (please tick the box if they are your carer)**

Full Name Mother		Relationship to You	
Address		Contact Number and other Details	
Full Name Father		Relationship to You	
Address		Contact Number and other Details	

Family History		Have your Parents, Brothers or Sisters had any of the following?	Relationship	Age of Onset	Sex	M/F
Please Tick	<input type="checkbox"/>	Diabetes				
	<input type="checkbox"/>	Heart Attack/Angina				
	<input type="checkbox"/>	Stroke				
	<input type="checkbox"/>	Bowel Cancer				
	<input type="checkbox"/>	Breast Cancer				
	<input type="checkbox"/>	Ovarian cancer				
	<input type="checkbox"/>	Thrombosis				