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| Children Patient Registration Form | | | Clipboard |
| Rev: Jan 2019 | | **Contact Details** | |
| Date |  | | |
| Name |  | | |
| Date of Birth (DOB) |  | | |
| Home Address |  | | |
| Telephone |  | | |
| Parents Names |  | | |
| Parents Occupations |  | | |
| School |  | | |
| GP |  | | |
| Name of the other healthcare professionals involved? |  | | |
| Are you under any specialist/hospital follow up? |  | | |
| Is your child followed by social services? |  | | |
| Contact details of social worker |  | | |
| **Medical Background** | | | |
| Present Complaint |  | | |
| Present Complaint History |  | | |
| Past Medical History |  | | |
| Hospital Admission?  Dates and reason for admission? |  | | |
| Any hereditary disorders in the family? |  | | |
| Any Accidents or Trauma? |  | | |
| Developmental delay? |  | | |
| Speech delay? |  | | |
| Behavioural problem? |  | | |
| Current Medications |  | | |
| Allergy |  | | |
| Appetite |  | | |
| Food Intolerances |  | | |
|  | **Diet** | | |
| Breakfast |  | | |
| Lunch |  | | |
| Dinner |  | | |
| Snacks |  | | |
| Alcohol |  | | |
| Fluid Intake |  | | |
| Any fizzy drinks |  | | |
| Tea or Coffee Consumptions |  | | |
|  | **Other** | | |
| How often do you open your bowels? |  | | |
| Urine  Incontinence?  Frequency?  Urine tract infections? |  | | |
| Any sleep problem? |  | | |
| Exercise |  | | |
| Vaccinations up-to-date? |  | | |
| Social History  Live in a house or flat?  How many people live at home?  Any pets? |  | | |
| Height/Weight |  | | |
| What would you like to achieve from your consultation? |  | | |
| The Referrer? |  | | |

Many thanks for filling the form

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| **!** | Please don’t forget to bring the personal child health record (**red book**), clinic letters and investigations results if you have any |