Dr Nur Ozyilmaz, Consultant

Integrative Health Specialist & Paediatrician

GMC: 60382367

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| <https://www.drnur.co.uk> |
| contact@drnur.co.uk |
| 58 South Molton Street, London, W1K 5SL |
| 020 7706 1997 |

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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? |  |
| UrineIncontinence?Frequency?Urine tract infections? |  |
| Any sleep problem? |  |
| Exercise |  |
| Vaccinations up-to-date? |  |
| Social HistoryLive 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 |