



New Patient Questionnaire

Please completed as fully as possible

Personal Information

Name

Date of birth

Email address

Mobile number

SMS Text messaging service

- Riverside Highland Medical Practice (RHMG) uses SMS to send text messages to patients for a range of purposes including appointment reminders, health check recalls, and requests to contact the practice
- The SMS service operates on implied consent; by providing a mobile number on your registration form you will be automatically consented for SMS messaging (*if over the age of 16*) unless you choose to decline this service.
- The mobile number provided for the SMS service must be your own mobile number & not that of a relative or friend.

I consent to being contacted by SMS and (or) email: Consent Decline

Ethnic origin

This is not compulsory but may be beneficial for your healthcare as certain health conditions are more common in specific communities and being aware of your origins may allow for early identification of these conditions.

What is your ethnic group?

Rather not say

Marital status

(Please tick)

Single Married Co-habiting Divorced/Separated Widowed

Further education / Occupation

Are you a carer for anyone who is frail, elderly or disabled?

Yes Whom:

No

Do you need an interpreter?

Yes Language required:

No

Next of kin details

Name:

Address:

Relationship:

Contact details (telephone, email etc.):

Please let us know of anyone else living at your address

Medication

Please provide details of any medications that you take on a regular basis, including any that you may purchase over the counter?

(Please include name, strength and how often you take this medication)

Please specify a pharmacy that you would like your prescriptions to be sent to for collection:

- | | | | |
|---|--|--|-----------------------------------|
| <input type="checkbox"/> Riverside Pharmacy Southside | <input type="checkbox"/> Boots Eastgate | <input type="checkbox"/> Boots Retail Park | <input type="checkbox"/> Boots |
| <input type="checkbox"/> Lochardil | <input type="checkbox"/> Superdrug (High street) | <input type="checkbox"/> Ness | <input type="checkbox"/> Culloden |
| <input type="checkbox"/> Kinmylies | <input type="checkbox"/> Tesco Retail Park | <input type="checkbox"/> Grant Street | <input type="checkbox"/> Dalneigh |
| <input type="checkbox"/> Park | <input type="checkbox"/> Great Glen | <input type="checkbox"/> Milton of Leyes | <input type="checkbox"/> Care |
| <input type="checkbox"/> Tornagrain | | | |

Please provide details of any diagnosed illnesses that you are currently receiving treatment for (i.e. Asthma, Diabetes);

Please provide details of any serious illness/ operations you have had in the last 10 years;

Please provide details of any vaccinations that you have had in the last 5 years;

Lifestyle

Smoking status *(Please tick)*

Never smoked Ex-smoker Current tobacco smoker Current e-cigarette/ vape smoker
If you are interested in stopping smoking please contact your local pharmacy for further advice/support.

Alcohol intake *(Please tick)*

Life-long teetotaler Ex-drinker Current drinker
If you are a current drinker please indicate how many units per week you consume:

Exercise *(Please tick)*

Exercise physically impossible Avoid trivial exercise Enjoy light exercise
Enjoy moderate exercise Enjoy heavy exercise

For patients with a cervix

Date of last cervical smear					
Contraception method used <i>(Please tick)</i>	Pill	Coil	Implant	Injection	None
For Coil/Implant, please add insertion date:					

If you are interested in discussing long acting reversible contraception please contact the Practice to arrange a suitable appointment.

Signature	
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Date	
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