Riverside Highland Medical Group

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:

☐Conon Bridge Pharmacy ☐Boots Fortrose ☐Boots Dingwall

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 teetotaller ☐ 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 ☐ Competitive athlete ☐

For patients with a cervix					
Date of last cervical smear					
Contraception method used *(Please tick)*	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	

Date	