**Riccarton General Practice**

***Dr Robert G Ewing Mrs Carol Pearson***

***Dr Catriona H Finlayson Practice Manager***

***Dr David R Millar***

***Dr Samantha Narro (Salaried GP Associate) Miss Dinah Day***

***Dr Jack Cunningham (Salaried GP Associate) Deputy Practice Manager***

This questionnaire is confidential

Please answer all the questions below:

**Patient Details (please print details):**

|  |  |
| --- | --- |
| **Sex:** | **Male □ Female □ Other (please specify):** |
| **Surname:** |  |
| **First Name:** |  |
| **Date of Birth:** |  |
| **Marital Status:** | **Single □ Married □ Other:** |
| **Mobile Phone Number:**  **(see text reminders for consent)** |  |
| **Email address:** |  |
| **Nationality:** |  |
| **Home Address & telephone number:** |  |
| **Occupation:** |  |

**Text Reminders (please indicate Yes or No):**

□ I give permission for Riccarton General Practice to contact me via text message regarding my booked appointment, and relevant healthcare activities eg. chronic disease reviews. I understand that I may withdraw my consent for text reminders at any time and I will contact Riccarton General Practice if this is the case. Riccarton General Practice holds all patient information with the strictest confidence and abides by Data Protection Legislation.

**Next of Kin:**

Name.......................................................................... Relationship...................................................................

Telephone Number:..............................................................................................................................................

Other details:

|  |  |
| --- | --- |
| **Height:** | **Weight:** |
| **Smoking Status:** Never Smoked □ Ex Smoker □ | Current smoker (amount per day) □ \_\_\_\_\_\_\_\_\_\_\_\_\_ |
| **Average Weekly Alcohol Intake**: | **Do you play sport/exercise regularly? (Please indicate Yes or No)** |

Do you suffer or have you suffered from any of the following? If any answers are yes would you please provide details:

|  |  |  |
| --- | --- | --- |
| **Medical Conditions:** | **Please indicate Yes or No** | **Date of Diagnosis (if known)/provide additional information:** |
| Asthma |  |  |
| Other Respiratory Disorders |  |  |
| Heart problems |  |  |
| Hypertension |  |  |
| Diabetes |  |  |
| Thyroid problems |  |  |
| Epilepsy (fits) |  |  |
| Other Neurological problems |  |  |
| Migraine |  |  |
| Psychological Illness |  |  |
| Have you ever had psychiatric treatment? |  |  |
| Specific Learning Difficulties |  |  |
| Gastrointestinal problems |  |  |
| Bladder or kidney problems |  |  |
| Blindness or eye problems |  |  |
| Deafness or ear problems |  |  |
| Eczema |  |  |
| Other skin conditions |  |  |
| Drug sensitivity/Allergies |  |  |
| Hay fever |  |  |
| Any other serious illness: |  |  |
| Any operations: |  |  |
| Any serious deformity/disability |  |  |

|  |
| --- |
| If any of these conditions or their effects still trouble you please give further details: |

**Present Medication (please specify)**

|  |  |  |
| --- | --- | --- |
| **Name of Drug** | **Strength** | **How Often Taken** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
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|  |  |  |
|  |  |  |

**Please attach sheet with additional information regarding medical conditions or prescriptions if necessary.**

**Cervical Screening:**

|  |
| --- |
| **Date of last cervical (Pap) smear (eligibility in the UK is from age 25)**  *Please include where it was taken, the result and the due date of next test. If previous test taken outside the UK, please provide a copy of your result.* |