Riverside Surgery
New Patient Questionnaire

Surname: First Names:

Date of Birth: Place of Birth:

Ethnicity:

Marital Status:

Occupation:

Address:

Home Telephone Number: Alternate Telephone Number (e.g. work):

Mobile Telephone Number:

E-mail Address:

We may at times need to contact you by telephone, SMS text or e-mail regarding test results or appointments. Please tick and sign below if you give permission for us to leave a message, send a text message (including appointment or review reminders) or send an e-mail.

☐I give permission for the staff at Riverside Surgery to leave a message on my telephone ‘asking me to contact the surgery’

☐ I give permission for the staff at Riverside Surgery to send me a text message

☐ I give permission for the staff at Riverside Surgery to send me an e-mail

☐ I understand that it is my responsibility to advise Riverside Surgery of any change in my contact details including mobile telephone number and e-mail address
Signed: Date:

Name of Next of Kin: Relationship:

Contact Number/Address for Next of Kin:

Are you a carer? ☐Yes ☐No
If yes, and you would like to register as a Carer please ask reception for a Carers Registration Form

Height: Weight:

Do you smoke? ☐Yes ☐No

If yes, how many per day:

If you are thinking about or trying to give up smoking, please ask at reception to book an appointment with one of our nursing team for smoking cessation help and advice.

Are you an ex smoker? ☐Yes ☐No

Do you drink alcohol? ☐Yes ☐No

If yes, how many units per day/week:

Medical History

Have you had any of the following conditions? (Please tick all that apply)

☐Asthma ☐Diabetes ☐Heart problems ☐High blood pressure ☐Other (please give details):

Have you had any operations or prolonged stays in hospital? (Please give details)

Family History

Has anyone in your family suffered from any of the following conditions? If so, which family member?

☐Asthma:

☐Diabetes:

☐Heart Disease:

☐High Blood Pressure:

☐Cancer (please specify which type of cancer):

Medication

Please provide us with a copy of your repeat medication list from your previous GP (if you do not have this available, please list your medications):

Do you take any Over-The-Counter Medications? ☐Yes (please give details) ☐No

Would you like to nominate a pharmacy so that we may send prescriptions directly there without you needing to come to collect from us? ☐Yes (please tell us which pharmacy) ☐No

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Allergies

Do you have any allergies? ☐Yes (please give details) ☐No

Female Patients

Have you ever been pregnant? ☐Yes ☐No
If so, how many times:

How many children do you have?

When did you last have a Smear Test?
Was the result normal? ☐Yes ☐No
If not, what follow up was recommended?

Are you using any contraception? ☐Yes ☐No
If yes, what form of contraception do you use?

Communication and Access Needs

Do you have any communication/access needs or requirements?

Do you need a format other than standard print?

How would you like us to communicate with you?

Can you explain what support would be helpful?

What is the best way to send you information?

Summary Care Record

If you have not received information previously, please ask at reception for an information pack.

Online Services

Riverside Surgery offers online services for patients to book and cancel GP appointments, order repeat medication and other facilities. If you would like to register for online services, please ask at reception (you will need photo ID to register).