RIVERVIEW MEDICAL CENTRE

NEW PATIENT INFORMATION FORM

Please provide as much information as you can

Name……

Date of birth……

Address (and keysafe code if you have one) ……..
……
……..

Who is your next of kin (name, relationship to you and contact phone number)……..……...
……..

Do you have a Power of Attorney in place?.....
If so who is this? ……..

Do you smoke? YES/NO (delete as applicable)
If YES, are you thinking about quitting? We have lots of information available at our reception to help you stop smoking.

How many units of alcohol do you drink per week? (1 unit is a small glass of wine, half a pint of lager or 1 small measure of spirits)…….

What is your height?.....

When was your last smear test (women only)……

Do you have any medical conditions? Please give details:
……
……
……

Do you take any regular medication which is prescribed by your GP or a hospital specialist? Please list these below:
……
……

Do you have any allergies? Please give details below:
……
……

Is there any history of the following in your family?

Condition	**Relative(s) affected and age at diagnosis (if known)**
Heart disease	
Stroke	
Diabetes	
High blood pressure	
Epilepsy	
Bowel Cancer	
Breast Cancer	
Ovarian Cancer	
Asthma	