The Maryhill Red Practice

First Name..Surname..

Address...

....

Date of Birth.. Marital Status..

Landline No..Mobile no..

Ethnicity..Do you require an interpreter YES/NO

If YES which language..

Next of Kin /Emergency Contact...

In the following questions please circle YES/NO

Do you suffer from Medication Allergies?   YES/NO If yes which ones?

....

Do you smoke? YES/NO

Have you ever smoked? If yes when did you stop.......................................

Do you drink alcohol? YES/NO   If yes how many units per week?............

Do you exercise? YES/NO   If yes how often per week?........................

How many portions of fruit/vegetables do you eat per day?........................

THE PRACTICE OFFERS A TEXTING SERVICE. THIS INVOLES REMINDERS REGARDING YOUR APPOINTMENTS, RESULTS OF ANY RECENT TESTS AND OTHER HEALTH CAMPAIGNS.

PLEASE CIRCLE BELOW YOUR PREFERENCE TO BE INCLUDED IN THIS SERVICE

CONSENT GIVEN   YES

CONSENT DECLINED   YES