Fairview Medical Centre

Welcome to **Fairview Medical Centre**. It may take several weeks for your records to reach us from your previous surgery. To help us care for you please complete this form. The information is confidential. If you have any queries or concerns do not hesitate to contact us.

Surname: **First Name:** **Telephone number:**

We are required by law to ask for your ethnic background, your ***first*** language and ***main spoken*** language. Please select the option you feel best describes you.

White	Mixed	Asian/ Asian British	Black/ Black British
British	White/Caribbean	Indian	African
Irish	White/ African	Pakistani	Caribbean
Other White	White/ Asian	Bangladeshi	Other Black
	Other Mixed	Other Asian	

First Spoken Language	Main Spoken Language	Do you speak English?
		Yes / No

Place of Birth:

We also need some personal information

Height:		**Weight:**	

No Exercise ☐ **Some Exercise** ☐ **Exercise 3 or more times per week** ☐

Have you ever smoked?	Do you smoke now?	If yes how many per day?
Yes / No	Yes / No	

If you do smoke and wish to give up we offer a comprehensive stop smoking programme which may include the prescribing of nicotine replacement patches or other medicines. This is a free NHS services for all our patients.

How many units of alcohol do you drink per week on average? :
(2 units = 1 glass of wine, 1 pint of beer/cider, 1 single measure of spirits)

Do you have a Carer? Y/N (Name - relationship & Tel No):-

Patient Email address:

Would you consider registering as an organ donor? Yes ☐ No ☐

Do you consent to Summary Care Record? Please tick ONE of the following:

Express consent for medication, allergies, and adverse reactions only ☐

Express consent for medication, allergies, adverse reactions, AND additional information ☐

Express dissent (opt out) ☐

Please answer further questions overleaf

Do you have any medical conditions?

Are you on any medications? If so, please provide details of all medications.

Next of Kin: Please provide THEIR details.

Name:	
Relationship to you:	
Date Of Birth:	
Address:	
Contact Number:	
Emergency Contact:	**Yes / No**
Discuss Record:	**Yes / No**
Are they registered at Fairview?	**Yes / No**

Patient Signature

X ______________________________ Date Signed: ___ / ___ / ___

All adults please provide original photo ID (passport) and proof of address (utility bill).
For all children we need to see original birth certificate/passport and their red book please.
If you are on regular medication please provide proof of all your medication.
Thank you.