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.

Title:	
First Name:	
Middle Name:	
Surname:	
Known As:	
Previous Surname (if applicable)	
Date of Birth	
Home Telephone number: **Mobile number:** **Work Number:**	
Email address:	
NHS Number:	
Place of birth:	
Which option best describes how you think of yourself?	☐ **Man (including trans man)** ☐ **Non-Binary** ☐ **Woman (including Trans woman)** ☐ **Other (please specify below)**
Is your Gender identity the same as the gender you were given at birth?	☐ **Yes** ☐ **No**
Which option best describes how you think of yourself?	☐ **Gay or Lesbian** ☐ **Heterosexual or Straight** ☐ **Bisexual** ☐ **In another way (please specify)** ☐ **I don't know\not sure**

Home Address

House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode:	

Previous Home Address (if applicable)

House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode	

Previous GP Address (if applicable)

House Name\Flat No.	
Number & Street	
Locality	
Town	
Postcode	

If you are from abroad

Your first UK address where registered with a GP	
If previously resident in the UK, date of leaving:	
Date you first came to live in the UK	

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**

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

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):-

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.

Patient Signature

X _____ Date Signed: ___ / ___ / ___

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.

PLEASE NOTE INCOMPLETED FORMS WILL BE DISCARDRED AFTER 7 DAYS