A logo for a medical center

Description automatically generated

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?** | **Stop outlineMan (including trans man) Stop outline Non-Binary**  **Stop outline Woman (including Trans woman) Stop outline Other (please specify below)** |
| **Is your Gender identity the same as the gender you were given at birth?** | **Stop outline Yes Stop outlineNo** |
| **Which option best describes how you think of yourself?** | **Stop outline Gay or Lesbian**  **Stop outline Heterosexual or Straight**  **Stop outline** **Bisexual**  **Stop outline** I**n another way (please specify)**  **Stop outline 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**Stop outline** No **Stop outline**

**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