FitzalanMedicalGroup | *Primary Medical Care in* LITTLEHAMPTON
Fitzalan Medical Group, Fitzalan Road, Littlehampton, West Sussex BN17 5JR

Tel: 01903 735200
Fax: 01903735222
Web: www.fitzalanmedicalgroup.com

Dear Patient,

May we take this opportunity to welcome you to our practice.

Please answer ALL of the questions below and bring it to the surgery as soon as possible. This gives us some information regarding your medical history, until your notes arrive from your previous GP. If you do not answer all of the questions your application may be held up.

Please Note: - that with your consent some of this information may be provided to insurance companies etc.

To help us provide you with the best care possible we ask that you provide details of ethnic origin and languages spoken.

Yours sincerely,
Fitzalan Medical Group

IMPORTANT NOTICE:

We will require identification to include proof of address for each patient registering with Fitzalan Medical Group. Please remember to bring your identification with you when you return the registration forms so we can deal with your registration promptly.

Acceptable forms of identification are: Driving licence / Utility bill / Passport

Patient Details*

Surname		Date of Birth	
Forenames		Sex:	M / F
Address		Martial Status	
		First Language	
Post Code		Ethnic Origin	
Contact Telephone No		Do you speak English	Y / N
Mobile No:		Fitzalan Medical Group offers a SMS / Text messaging service to remind patients of booked appointments for some clinics. Do you consent to us contacting you in this way**	Y / N

*** Please note: If you change your number we will need to know as soon as possible so we can update your records*

Medications and Allergies*

Do you have any repeat medications?	Y / N	Please attach copy of Repeat order form	
Are you allergic to any medications:	Y / N	If Yes, please give details:	

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Do you have any other allergies? e.g. food	Y / N	If Yes, please give details:	
Please give any information you feel may be relevant to your current health:			

Family History*

Do you have a family history of any of the following: *(Please ring appropriate answer)*		
Heart Disease	Y / N	If yes, who?
Strokes	Y / N	If yes, who?
High Blood Pressures	Y / N	If yes, who?
Diabetes	Y / N	If yes, who?
Do any other serious illnesses run in your family?	Y / N	If yes, please give details

Basic Information*

Do you have a family history of any of the following: *(Please ring appropriate answer)*			
Do you smoke	Y / N	If yes, how many per day?	
Have you ever smoked	Y / N	If yes, when did you stop?	
How often do you have a drink that contains alcohol?	Never / Less than monthly / Monthly / Weekly / Daily or almost daily		
How many standard alcohol drinks do you have on a typical day when you are drinking?	1 – 2 / 3 – 4 / 5 – 6 / 7 – 9 / 10+		
How often do you have 6 or more standard drinks on one occasion?	Never / Less than monthly / Monthly / Weekly / Daily or almost daily		
How tall are you?		How much do you weigh?	
Recent Blood Pressure Reading	*(Please use the machine in Reception to do this)*		
Women Only:			
Date of your last cervical smear			
Have you had a hysterectomy?	Y / N	If yes, please give details	

Carers*

Are you are carer?	Y / N	If yes, who?
Are they a patient at this surgery?	Y / N	If yes, who?
Do you have a carer?	Y / N	If yes, who?