SYNCMED HEALTHCARE NIGERIA

Elite Concierge Home Health Services

COMPREHENSIVE MEMBER HEALTH INTAKE FORM

For office use: this form initiates the SyncMed member health record. All information is confidential and protected under SyncMed's Privacy First protocol. Please complete in full; leave a field blank only if genuinely not applicable.

Member ID:		**Intake Date:**	
Case Manager / RN:		**Membership Tier:**	

1. MEMBER INFORMATION

Full Legal Name	
Preferred Name	
Date of Birth	
Sex Assigned at Birth / Gender Identity	
Nationality	
Occupation / Employer	
Passport / National ID Number	
Primary Phone (WhatsApp-enabled preferred)	
Secondary Phone	
Email Address	
Marital Status	

Residential Address (Home Visit Location)

Street Address	
Estate / Compound Name	
City / LGA	

State	
Landmark / Directions	
GPS Coordinates (if available)	

2. HOME ACCESS & VISIT LOGISTICS

This section ensures our clinical team can reach you promptly — critical to our Zero Latency pillar.

Gate Code / Security Post Instructions	
Parking Availability	
Floor / Unit Number (if apartment)	
Preferred Visit Days	
Preferred Visit Time Window	
Household Staff Present During Visits (driver, steward, nanny)	
Pets on Premises	

3. EMERGENCY CONTACT & NEXT OF KIN

Full Name	
Relationship to Member	
Phone Number(s)	
Email Address	
Also Authorized to Receive Health Updates? (Y/N)	

4. MEMBERSHIP & SERVICE PREFERENCES

☐Individual ☐Family ☐Corporate / Expatriate Package

☐Silver ☐Gold ☐Platinum

Services of Interest

☐Routine Home Visits	☐24/7 Telemedicine	☐Chronic Disease Management
☐Executive Health Screening	☐Longevity / Wellness Program	☐Medication Management
☐Diagnostics at Home (labs/imaging)	☐International Referral Coordination	☐Travel Health / Medical Evacuation
☐Post-Surgical / Post-Hospital Care	☐Pediatric Care	☐Mental Health & Counseling

5. INSURANCE & BILLING INFORMATION

Health Insurance Provider (if any)	
Policy / Membership Number	
Corporate Sponsor (if employer-paid)	
Preferred Billing Method	
Billing Contact Name & Phone (if different from member)	

6. REASON FOR ENROLLMENT / CHIEF HEALTH CONCERN

Describe, in the member's own words, the primary reason for joining SyncMed and any immediate health concerns.

7. PAST MEDICAL HISTORY

Known Medical Conditions

☐Hypertension	☐Diabetes Mellitus (Type 1/2)	☐Heart Disease / Arrhythmia
☐Stroke / TIA	☐Asthma / COPD	☐Kidney Disease
☐Liver Disease	☐Thyroid Disorder	☐Cancer (specify below)
☐HIV / Immune Disorder	☐Sickle Cell Disease / Trait	☐Arthritis / Joint Disease
☐Anxiety / Depression	☐Sleep Disorder	☐Obesity

Other Conditions / Details	
Year(s) of Diagnosis	

Past Surgeries / Hospitalizations

8. CURRENT MEDICATIONS & SUPPLEMENTS

Medication Name	Dose	Route	Frequency	Prescribing Physician

9. ALLERGIES

Drug Allergies (list + reaction)	

Food Allergies	

Environmental Allergies (latex, pollen, etc.)	

10. FAMILY MEDICAL HISTORY

☐Diabetes	☐Hypertension	☐Heart Disease
☐Stroke	☐Cancer	☐Kidney Disease
☐Mental Illness	☐Sickle Cell Disease	☐Other Genetic Conditions

Please note relationship to member (e.g., mother, father, sibling) for any items checked above:

11. SOCIAL HISTORY & LIFESTYLE

Alcohol Use (frequency/type)	
Tobacco / Nicotine Use	
Recreational Drug Use	
Exercise Frequency & Type	
Diet Type / Restrictions	
Average Sleep Hours	
Occupational Stress Level (Low/Med/High)	
Frequent International Travel? (destinations)	

12. REVIEW OF SYSTEMS

Check any symptoms currently or recently experienced.

☐Fever / Chills	☐Unexplained Weight Change	☐Fatigue
☐Chest Pain	☐Palpitations	☐Shortness of Breath
☐Cough	☐Abdominal Pain	☐Nausea / Vomiting
☐Change in Bowel Habits	☐Urinary Symptoms	☐Joint / Muscle Pain
☐Headaches	☐Dizziness	☐Vision Changes
☐Hearing Changes	☐Skin Changes / Rash	☐Mood Changes
☐Sleep Disturbance	☐Memory Concerns	☐Numbness / Tingling

13. BASELINE VITALS & MEASUREMENTS

Completed by SyncMed clinician at first home visit.

BP		**HR**	
Temp		**SpO2**	
RR		**Weight (kg)**	
Height (cm)		**BMI**	

Blood Glucose (RBS/FBS)	
Waist Circumference	

14. FUNCTIONAL ASSESSMENT (ACTIVITIES OF DAILY LIVING)

Activity	Independent	Needs Assistance	Dependent
Bathing	☐	☐	☐
Dressing	☐	☐	☐
Toileting	☐	☐	☐
Transferring (bed/chair)	☐	☐	☐
Mobility / Ambulation	☐	☐	☐

Feeding	☐	☐	☐
Medication Self-Administration	☐	☐	☐
Managing Finances	☐	☐	☐
Using Telephone / Communication	☐	☐	☐

15. HOME SAFETY ASSESSMENT

Completed by SyncMed clinician during initial home visit.

☐Adequate Lighting	☐Clear Walkways / No Trip Hazards	☐Working Smoke Detector
☐Grab Bars in Bathroom	☐Stable Staircase / Handrails	☐Accessible Emergency Exit
☐Functional Refrigeration for Medications	☐Backup Power Supply (generator/inverter)	☐Reliable Water Supply
Home Safety Notes / Concerns		

16. GLOBAL CARE & TRAVEL PREFERENCES

Preferred International Hospital / Network (if any)	
Existing Medical Evacuation Coverage	
Passport Expiry Date	
Countries Visited in Last 12 Months	
Preferred Language for International Coordination	

17. ADVANCE DIRECTIVES & PREFERENCES

☐Living Will on File ☐None

☐Organ Donor ☐Not Registered

Preferred Hospital for Emergency Admission	
Religious / Cultural Considerations for Care	

18. CONSENT & AUTHORIZATION

I confirm that the information provided in this intake form is accurate and complete to the best of my knowledge. I understand that SyncMed Healthcare Nigeria will use this information to develop my personalized concierge care plan, and that my data will be handled under SyncMed's Privacy First protocol and applicable Nigerian data protection law (NDPR).

☐I consent to home visits by SyncMed clinical staff

☐I consent to telemedicine consultations

☐I consent to sharing my records with referral specialists/hospitals as needed for my care

☐I consent to emergency contact notification in the event of a medical emergency

Member Signature		**Date**	

Witness / Clinician Signature		**Date**	