Welcome to Brookfield Centre for Lifestyle Medicine.
Please carefully complete this registration form. We seek to plan services that can help to improve and maintain your health. Your answers will help us to do this.

We may ask you more questions regarding your answers so a member of the reception team will go through your completed form with you. If you have any problems completing the form please ask for help at the reception.

Once you have completed this form, the receptionist will help you if you need to book an appointment. You will also be given our practice leaflets as well as other relevant information.

If you have any problems completing the form, please ask for help at the reception.
REGISTRATION FORM A

PERSONAL DETAILS

FIRSTNAME: ___________________________ MIDDLENAME: ___________________________
LASTNAME: ___________________________ MAIDEN NAME: __________________________

GENDER: [M or F in capital letters] DATE OF BIRTH: [DD MM YYYY]

TITLE: [Mr, Mrs, Others] AGE: [Figures] OCCUPATION: [In capital letters]

RELIGION: [Christian] [Tick] ISLAM [Tick] OTHERS: [In capital letters]


ADDRESS: [Capital letters]

EMAIL: ___________________________

PHONE NO.: [Country Code and Phone Number, Mobile Phone Number first] NHIS Number: [If Known]

HMO Number: ___________________________

Do you have a Private Medical Insurance: YES [Tick] NO [Tick]

If yes, Name of Insurance Company: [Capital letters]

Address of Insurance Company: [Capital letters]

EMAIL: ___________________________

PHONE NO.: [Country Code and Phone Number, Mobile Phone Number first]
The next questions will help us to establish contact with your Next of Kin when necessary. Your Next of Kin may be required to provide information or provide consents in emergency situations.

**NAME OF NEXT OF KIN:** (Firstname and Lastname in capital letters)

FIRSTNAME: ___________ LASTNAME: ___________

**NEXT OF KIN’S RELATIONSHIP TO YOU:** (e.g., Wife, Brother, Son, Uncle etc., in capital letters)

________________________________________________________________________

**ADDRESS OF NEXT OF KIN:** (Capital letters)

________________________________________________________________________

**PHONE NO.:** (Country Code and Phone Number, Mobile Phone Number first)

________________________________________________________________________

Is your Next of Kin registered at this practice?: (Y for Yes, N for No)

☐

The next questions will help us to establish if you have any previous NHIS medical records and assist us in tracing those records. Please give as much information as possible.

**PLACE OF REGISTRATION:** (in capital letters)

________________________________________________________________________

**NAME OF YOUR PREVIOUS HEALTH CARE PROVIDER IN NIGERIA:** (Capital letters)

________________________________________________________________________

**RACE:**

☐ Black

☐ Other Black Backgrounds: (in Capital Letters) ___________

☐ White

☐ British

☐ European

☐ American

☐ Canadian

☐ Other White Background: (in Capital Letters) ___________

☐ Asian/Middle East

☐ Indian

☐ Chinese

☐ Lebanese

☐ Canadian

☐ Other Asian Background: (in Capital Letters) ___________

☐ Mixed

☐ Black/European

☐ Black/Asian

☐ White/Asian

☐ Other Mixed Background: (in Capital Letters) ___________

**ETHNICITY:**

☐ Hausa

☐ Ibo

☐ Yoruba

☐ Others: (in Capital Letters) ___________

Your First Language:

________________________________________________________________________

Do you need us to book you an interpreter for your appointments?: (Y for Yes, N for No)

☐

Where did you hear about us?: (tick below)

☐ Website

☐ Flyer

☐ Embassy

☐ Facebook

☐ Personal Recommendation

☐ Others

________________________________________________________________________

FOR PRACTICE USE ONLY

Computer Number: ____________________________

Form checked by: ____________________________

Information given: ____________________________

Entered by: ____________________________

Date entered: ____________________________
REGISTRATION FORM B

MEDICATION:
Are you on any regular medication?    YES    NO

If yes, please list your medications including dosage if known

Do you have any drug/food/nuts allergies?    YES    NO

If yes, please list what these are

MALARIA PREVENTION ADVICE AND MALARIA CHEMOPROPHYLAXIS:

Are you on any malaria Tablets for prevention?    (tick for Yes)

- Chloroquine + Proguanil  
- Atovaquone + Proguanil (Malarone)  
- Mefloquine  
- Chloroquine  
- Doxycycline

Others, Please Indicate:

PERSONAL MEDICAL HISTORY:(Please tick the box if you have any of the following illnesses)

Diabetes:    YES    NO    Date of Diagnosis: (DD MM YYYY)

Details:

High Blood Pressure:    YES    NO    Date of Diagnosis: (DD MM YYYY)

Details:
PERSONAL MEDICAL HISTORY: (Please tick the box if you have any of the following illnesses)

Heart Attack/Heart problem: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Stroke: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Cancer: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Overactive thyroid (Hyperthyroidism): YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Epilepsy: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Asthma: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Any Mental Health problems (e.g. depression): YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Stomach/Bowel problem: YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:

Underactive thyroid (Hypothyroidism): YES (tick)  NO (tick)  Date of Diagnosis: (DD MM YYYY)
Details:
### PERSONAL MEDICAL HISTORY:
(Please tick the box if you have any of the following illnesses)

- **Any other illness?**
  - YES [ ]
  - NO [ ]
- **Date of Diagnosis:**
  - (DD MM YYYY) [ ]

Details:

- Any Operation(s)?
  - YES [ ]
  - NO [ ]
- **Date of Diagnosis:**
  - (DD MM YYYY) [ ]

Details:

### FAMILY MEDICAL HISTORY:
Has anyone in your immediate family ever suffered from?

- **HEART DISEASE:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **THYROID PROBLEMS:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **DIABETES:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **ANY FORM OF CANCER:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **MENTAL HEALTH PROBLEMS:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **BOWEL PROBLEMS:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **SUDDEN DEATH:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **HYPERTENSION:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **STROKE:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **OBESITY/OVER WEIGHT:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **ASTHMA:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

- **EPILEPSY:**
  - YES [ ]
  - NO [ ]
  - DONT KNOW [ ]

### FATHER
- Any serious illnesses?
  - YES [ ]
  - NO [ ]
- **Alive/Well:**
  - Age at onset: (figures) [ ]

If Yes, please describe

- If he is dead? [ ]
  - Age at death: (figures) [ ]

What was the cause of death?

### MOTHER
- Any serious illnesses?
  - YES [ ]
  - NO [ ]
- **Alive/Well:**
  - Age at onset: (figures) [ ]

If Yes, please describe

- If she is dead? [ ]
  - Age at death: (figures) [ ]

What was the cause of death?
**VACCINATION HISTORY:**

Have you had any of the following vaccinations?  

<table>
<thead>
<tr>
<th>Vaccination</th>
<th>YES (tick)</th>
<th>NO (tick)</th>
<th>Date of Vaccinations: DD MM YYYY</th>
</tr>
</thead>
<tbody>
<tr>
<td>TETANUS</td>
<td></td>
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<tr>
<td>TYPHOID</td>
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<td>RABIES</td>
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<td>POLIO</td>
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<td>HEPATITIS A</td>
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<tr>
<td>HEPATITIS B</td>
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<tr>
<td>YELLOW FEVER</td>
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<tr>
<td>JAPANESE B ENCEPH</td>
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<tr>
<td>DIPHTHERIA</td>
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<tr>
<td>INFLUENZA</td>
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<tr>
<td>TICK BORNE</td>
<td></td>
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<tr>
<td>PERTUSIS(WHOOPING COUGH)</td>
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<tr>
<td>MEASLES</td>
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<td>MUMPS</td>
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<tr>
<td>TUBERCLOSIS</td>
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<tr>
<td>HAEMOPHILUS INFLUENZA B(HIB)</td>
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<tr>
<td>MENINGITIS A</td>
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<tr>
<td>MENINGITIS C</td>
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<tr>
<td>RUBELLA</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Others

---

**Number of Siblings:**

- [ ] BROTHER (tick)
- [ ] SISTER (tick)

Any serious illnesses?: (tick)

If Yes, please describe

- [ ] If he/she is dead?: (tick)

What was the cause of death?

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**REGISTRATION FORM C**

**LIFESTYLE DETAILS**

**ANTHROPOMETRY DETAILS:** (Body measurements and proportions)

**WEIGHT** (state unit of measurement eg inches, feet, kg, metres)

**WAIST CIRCUMFERENCE** (state unit of measurement eg inches, feet, kg, metres)

**MID ARM CIRCUMFERENCE** (state unit of measurement eg inches, feet, kg, metres)

**HEIGHT** (state unit of measurement eg inches, feet, kg, metres)

**BODY MASS INDEX.** (state unit of measurement eg inches, feet, kg, metres)

---

**EXERCISE:**

Do you do regular exercise? YES (tick) NO (tick)

If yes, What kind of exercise?

How many times a week do you exercise?

- [ ] 1-2 times
- [ ] 3-4 times
- [ ] 5-7 times

How long is your typical exercise session?

- [ ] 5-10 mins
- [ ] 15-30 mins
- [ ] 30-60 mins
- [ ] 1hr and above

Please tick the relevant box(es) below:

- [ ] I have a Gym Membership
- [ ] I have a Home Gym
- [ ] I have a personal Trainer

---

Regular exercise and a good diet help to keep your heart healthy. Ask us for advice.

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**SMOKING:**

Do you currently smoke? YES (tick) NO (tick)

How long have you been smoking? [ ] Years (in figures)

If yes, how many cigarettes do you smoke every day? [ ] Number of Sticks smoked daily (in figures)

Have you ever smoked? YES (tick) NO (tick)

How many years ago did you stop smoking? [ ] Years (in figures)

If so, how many did you smoke every day before you stopped? [ ] Number of Sticks smoked daily (in figures)

---

Tobacco smoking is the biggest cause of preventable illness and death. If you want help to stop please ask for an appointment with a smoking cessation advisor.
SLEEP:
Describe your sleep patterns:

At least 8 hours of night time sleep is recommended for health and well being.

DIET/NUTRITION:
Do you eat regularly? YES (tick) NO (tick)
Do you skip meals? YES (tick) NO (tick)
Do you take sugar/honey in your tea/coffee? YES (tick) NO (tick)
Do you understand the caloric value of what you eat or drink? YES (tick) NO (tick)
Do you eat lots of fruits and vegetables? YES (tick) NO (tick)
Have you done any juicing programme? YES (tick) NO (tick)

Eating a healthy, balanced diet with your correct caloric requirement is an important part of maintaining good health and can help you feel your best too.

A few small changes can help you and your family get the recommended 5 portions of fruits and vegetables a day in an easy and affordable manner.

BLOOD PRESSURE:
When did you last have your blood pressure measured? Date: DD MM YYYY
Do you know what your reading was?
Systolic [ ] Diastolic [ ] OR [ ] Normal (tick if normal) [ ] Abnormal (tick if abnormal)

If you are aged 45 or over you should have your blood pressure checked every year. If your last blood pressure check was abnormal or if you cannot remember the result please make an appointment to see the Practice Nurse to get it checked.

CONTRACEPTION AND SEXUAL HEALTH:
Do you use contraception? YES (tick) NO (tick)
What do you use? (tick options below)
- Condoms
- Contraceptive Pills
- IUD/Coil
- Implant
- Diaphragm
- Depo provera injection
- Patch

We offer a full range of contraception including emergency contraception (the morning after pill). Ask any of our doctors if you would want a sexual health screen.
ALCOHOL:
TO HELP US PROVIDE YOU WITH FURTHER ADVICE CAN YOU PLEASE ANSWER THE FOLLOWING QUESTIONS ABOUT YOUR ALCOHOL USE:

How often do you take drink that contains alcohol?
- Never
- Monthly or less
- 2-4 times per month
- 2-3 times per week
- 4+ times per week

How many standard alcoholic drinks do you have on a typical day when you are drinking?
- 1-2
- 3-4
- 5-6
- 7-8
- 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 often during the last year have you been unable to remember what happened the night before because you had been drinking?
- Never
- less than Monthly
- Monthly
- Weekly
- Daily or almost Daily.

How often during the last year have you failed to do what was normally expected of you because of drinking?
- Never
- less than Monthly
- Monthly
- Weekly
- Daily or almost Daily.

In the last year, has a relative or friend, or a doctor been concerned about your drinking and suggested that you cut down?
- Never
- less than Monthly
- Monthly
- Weekly
- Daily or almost Daily.

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Men can take 3 units of alcohol per day and Women can take 2 units of alcohol per day. More than 21 units per week for men and 14 units for women can damage your health. Ask a Doctor or Nurse for more advice!

Two (2) units of alcohol is found in one pint of Beer/ Stout/ Ale/ small glass of Wine/ a tot of Gin.

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THIS SECTION IS FOR WOMEN ONLY TO COMPLETE

Women who are sexually active and aged between 25 and 64 should have a cervical smear test every 3 years. This can prevent cancer in later life. In Brookfield, we have a screening programme that invites women to have their smears done.

Have you ever had a smear? **YES** (tick) **NO** (tick) Date of last Smear: (DD MM YYYY)

Where was the last Smear done?

What was the result? (tick result options)
- Normal
- Abnormal
- Inadequate specimen

Have you ever had a Breast Mammogram? **YES** (tick) **NO** (tick)

What was the last result? (tick result options)
- Normal
- Abnormal

Do you have Regular Breast Self Examination? **YES** (tick) **NO** (tick)

---

If your smear test is due or you are 21 or over and have never had a smear test please book an appointment with a Doctor.
To the best of my knowledge, information given in the registration form is correct.

PAYMENT OF FEES.
Fees are payable at the time of consultation by cash or POS.

STATEMENT.
I have read through the services that the Brookfield Centre for Lifestyle Medicine is able to provide. In particular, I agree to the current charges for specialist consultations, telephone consultations and prescriptions, home visits and home screens. I agree to settle any payment due to the Brookfield Centre for Lifestyle Medicine at the time of consultation.

I also understand that failure to do so will result in an additional administrative charge being added to my account. This applies to either myself or my family (This does not apply if you belong to a health maintenance organization or you are on a retainership programme). A cancellation charge of 50% of the fee may be levied if less than 4 hours notice is given.

PROVISION OF SERVICES.
This form is a registration for the provision of healthcare services by the practice for the above named patient and, if also registered, their family. These services will be provided according to registration status as documented in full in the patient guide.

By Signing this form, you are agreeing to these terms and those outlined in the brochure and giving consent for the practice to perform its duties according to the stipulated policies of the practice.

SIGNED ..............................................................

DATE ..............................................................

THANK YOU FOR COMPLETING THIS FORM

Your registration should take about 24hrs to process. If you need to make an appointment to see one of our team sooner than this, please speak to a member of the reception team who can book you an appointment. If you have not had a practice leaflet please ask for one at reception.

Please note; in the event of a home visit being necessary, doctors from the Brookfield Centre for Lifestyle Medicine will endeavor to carry this out. This service is chargeable.