Northwestern Memorial® Hospital

PATIENT HEALTH HISTORY

FOR OFFICE USE ONLY IF HAVING SURGERY:
Please fax a copy of this form to 312.694.9712 and keep a copy for your files.
Scheduled Surgery Date _____
Procedure _____
Has this patient been scheduled for pre-operative testing? ☐ Yes ☐ No
Surgeon _____

The patient health history questionnaire helps the physicians and nurses to evaluate your health and plan your care. Please fill out this form to the best of your ability. We may call you to ask additional questions. Thank you.

Name _____ Date of Birth _____ Today's Date _____

Preferred Phone Number(s) (day) _____ (night) _____

Primary Care Physician / Internist _____ PCP Phone # / Location _____

*** Have you previously received medical care at Northwestern Memorial Hospital? ☐ Yes ☐ No**

Height _____ Weight _____ Primary Language _____

ALLERGIES: List any allergies to drugs or other materials (e.g. latex). What was the reaction?

_____

CURRENT MEDICATIONS (If you have a brought a list of your current medications, we will make a copy and attach it to this form.)

List your current medications (include prescriptions, over-the-counter medications, birth control pills, etc.):

Medication Name	Dosage / Frequency / Route	Medication Name	Dosage / Frequency / Route

MEDICAL HISTORY List all past surgeries or hospital stays:

Reason (type of surgery or illness)	Date	Where treated?

Have you ever had problems with anesthesia? ☐ No ☐ Yes

If 'Yes' please describe the problem you experienced: _____

Have your family members ever had problems with anesthesia? ☐ No ☐ Yes ☐ Unsure

If 'Yes' please describe the problem experienced:

_____

Please provide your name once more: _____

Do you have heart problems (cardiovascular disease)? ☐ No ☐ Hypertension
☐ Heart Valve Abnormality ☐ Abnormal Heart Rhythm / Palpitations ☐ Pacemaker/Defibrillator (Provide model)
☐ Chest Pain / Angina ☐ Heart Attack ☐ Angioplasty / Stent ☐ Heart Surgery ☐ Congestive Heart Failure
☐ Other

What is your level of activity?
☐ Able to walk / run a mile in 15 minutes ☐ Able to walk 2 blocks without stopping ☐ Able to walk up a flight of stairs
☐ Able to complete normal activities of daily living ☐ Unable to do any of the above activities

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Do you have lung (pulmonary) problems?
☐ No ☐ Asthma ☐ Chronic Bronchitis ☐ Emphysema / COPD ☐ Pneumonia ☐ Pulmonary Hypertension
☐ Respiratory Infection ☐ Recent Cold / Flu ☐ Tuberculosis ☐ Other

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Do you use oxygen at home? ☐ No ☐ Yes

Do you have sleep disorders? ☐ No ☐ Stop Breathing During Sleep ☐ Daytime Drowsiness ☐ Loud Snoring
☐ Diagnosed Sleep Apnea (Do you use CPAP? Settings?) _____ ☐ Other

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Do you have liver / stomach / gastrointestinal problems? ☐ No ☐ Hiatal Hernia ☐ Acid Reflux/GERD
☐ Liver Disease ☐ Hepatitis ☐ Cirrhosis ☐ Ulcer ☐ Crohn's Disease ☐ Ulcerative Colitis
☐ Irritable Bowel Syndrome ☐ Other

Do you have kidney (renal) problems? ☐ No ☐ Kidney Failure ☐ Dialysis ☐ Other

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Do you have endocrine problems? ☐ No ☐ Diabetes ☐ Thyroid Disease ☐ Addison's ☐ Other

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Do you have brain or musculoskeletal (neurologic / nervous system) problems? ☐ No ☐ CVA / TIA (Stroke)
☐ Seizures ☐ Multiple Sclerosis ☐ Brain Aneurysm / AVM ☐ Brain Tumor ☐ Cerebral Palsy
☐ Spinal Cord Injury ☐ Muscular Dystrophy ☐ Myasthenia Gravis ☐ Other

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Are you currently being treated for psychiatric disorders? ☐ No ☐ Depression ☐ Bipolar Disorder
☐ Anxiety Disorder ☐ Panic Attacks ☐ Schizophrenia ☐ Other

Do you have any skin problems? ☐ No ☐ Active Shingles ☐ Eczema ☐ Open Wound ☐ New Rash ☐ Other

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Do you have blood (hematologic problems)? ☐ No ☐ Hemophilia ☐ Bleeding Disorder
☐ Bleed or bruise easily ☐ Family history of bleeding disorder ☐ Anemia ☐ Sickle Cell Anemia / Trait
☐ (Prior) Transfusions ☐ HIV ☐ Blood clots ☐ Other

Do you have any history of cancer? ☐ No ☐ Yes If yes, please list type, treatment(s) and date of last chemotherapy or radiation:

ADDITIONAL INFORMATION

Do you use tobacco? ☐ No, never ☐ Yes: Packs per day _____ for _____ years Quit (year) _____

Do you drink alcohol? ☐ No ☐ Past ☐ Current
On average, how many alcoholic drinks do you consume? _____ per day _____ per week

Do you use recreational drugs? ☐ No ☐ Past ☐ Current Type of drug used _____

Have you had unplanned weight loss within the past 6 months? ☐ No ☐ Yes ☐ Unsure

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