

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

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

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

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

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

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

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

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
