

FOR PHYSICIAN'S OFFICE USE ONLY
Physician _____
Procedure _____
Procedure date _____
FAX this completed form to: 312-926-9081

Name _____ Date of Birth _____

Email address _____ Gender FEMALE MALE

Phone number (Day) _____ Height _____ Weight _____
(Evening) _____

Preferred method of contact _____ Occupation _____

Primary care physician _____ Marital Status _____

Physician office location _____ Do you need an interpreter? YES NO

Physician office phone _____ If so, what language? _____

MEDICAL HISTORY: List all past surgeries and hospitalizations

Reason (type of surgery or illness)	at NMH?	Year

1. Have you ever had problems with anesthesia?
YES NO

If yes, what type of problem?

2. Has anyone in your family ever had problems with anesthesia?
UNSURE YES NO

If yes, what type of problem?

3. Do you have any allergies to medications?
YES NO

If yes, what medications & what reactions have you had?

MEDICATIONS: List all of your medications here or attach a list (Include supplements, vitamins and over the counter medications)

Name	Dose	# of Times/Day

4. Are you allergic to latex or other materials?
YES NO

If yes, what material & what reaction did you have?

5. Have you ever been treated at Northwestern Memorial Hospital before?
YES NO



NMH Health History Form Page 2

Name _____

Do you have any of the following problems? In each category, please check ALL that apply.

Heart/Artery Problems:	<input type="checkbox"/> Chest pain or angina <input type="checkbox"/> Heart attack <input type="checkbox"/> Angioplasty or heart stents <input type="checkbox"/> Heart surgery <input type="checkbox"/> Atrial fibrillation <input type="checkbox"/> Heart failure	<input type="checkbox"/> Peripheral vascular disease <input type="checkbox"/> Blockages in your arteries <input type="checkbox"/> Aortic aneurysm <input type="checkbox"/> Heart valve disease (not MVP) <input type="checkbox"/> Defibrillator (AICD) <input type="checkbox"/> Pacemaker	<input type="checkbox"/> High blood pressure <input type="checkbox"/> NONE
Lung Problems:	<input type="checkbox"/> Emphysema <input type="checkbox"/> COPD <input type="checkbox"/> Recent pneumonia (last 3 months)	<input type="checkbox"/> Use of Oxygen at home <input type="checkbox"/> Recent TB (tuberculosis) <input type="checkbox"/> Pulmonary hypertension <input type="checkbox"/> Cold or flu in last week	<input type="checkbox"/> Asthma <input type="checkbox"/> NONE
Sleep Problems:	<input type="checkbox"/> Loud snoring <input type="checkbox"/> Stop breathing during sleep or have sleep apnea <input type="checkbox"/> CPAP		<input type="checkbox"/> Daytime drowsiness <input type="checkbox"/> NONE
Liver or Stomach Problems:	<input type="checkbox"/> Active Crohn's or Ulcerative Colitis <input type="checkbox"/> Recent stomach ulcer <input type="checkbox"/> Liver transplant	<input type="checkbox"/> Hepatitis <input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Reflux or GERD <input type="checkbox"/> Hiatal hernia <input type="checkbox"/> NONE
Urine or Kidney Problems:	<input type="checkbox"/> Impaired kidney function <input type="checkbox"/> Dialysis <input type="checkbox"/> Kidney transplant		<input type="checkbox"/> Bladder infection or UTI <input type="checkbox"/> NONE
Gland Problems:	<input type="checkbox"/> Diabetes <input type="checkbox"/> Take prednisone or other steroids	<input type="checkbox"/> Adrenal problems <input type="checkbox"/> Pituitary problems	<input type="checkbox"/> Thyroid problems <input type="checkbox"/> NONE
Brain, Spinal Cord, Nervous System Disease:	<input type="checkbox"/> Stroke or TIA <input type="checkbox"/> MS (Multiple sclerosis) <input type="checkbox"/> Parkinson's <input type="checkbox"/> Brain aneurysm or AVM	<input type="checkbox"/> Brain tumor <input type="checkbox"/> Spinal cord injury <input type="checkbox"/> Myasthenia Gravis <input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Seizure Disorder <input type="checkbox"/> Cerebral Palsy <input type="checkbox"/> NONE
Skin Problems:	<input type="checkbox"/> Active Shingles <input type="checkbox"/> New Rash or open wound		<input type="checkbox"/> Eczema <input type="checkbox"/> NONE
Bleeding or Clotting Disorder:	<input type="checkbox"/> Hemophilia <input type="checkbox"/> Bleeding Disorder <input type="checkbox"/> Bleed or bruise easily <input type="checkbox"/> Sickle Cell Disease	<input type="checkbox"/> Use blood thinner medications <input type="checkbox"/> Blood clots <input type="checkbox"/> Anemia	<input type="checkbox"/> Family history of bleeding disorder <input type="checkbox"/> NONE
Other Issues:	<input type="checkbox"/> Active Leukemia or lymphoma <input type="checkbox"/> Multiple Myeloma <input type="checkbox"/> Chemotherapy in last 6 weeks	<input type="checkbox"/> Amyloidosis <input type="checkbox"/> HIV	<input type="checkbox"/> Mood or psychiatric disorders <input type="checkbox"/> NONE
Are you a Jehovah's Witness?	YES	NO	
Are you currently pregnant?	YES	NO	
Have you had unplanned weight loss of more than 20 pounds in the last 6 months?	YES	NO	
Have you smoked for more than 25 years (now or ever?)	YES	NO	
Do you drink more than 2 alcoholic drinks a day or 14 drinks a week?	YES	NO	
Have you used recreational drugs other than marijuana in the last 3 months?	YES	NO	
If so, what kind? _____			
Do you have other significant medical problems? If so, what are they?: _____			