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?

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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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Why are you seeing the doctor today?

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Where is your pain?

☐Right Hip ☐Right Knee ☐Low Back ☐Left Hip ☐Left Knee ☐Back of Legs

How long have you had this problem? ____

If you are having **HIP PAIN**, where is it located?

☐ Groin ☐ Thigh ☐Below Knee ☐ Side Hip ☐ Down to Knee ☐ Down to Foot

If you are having **KNEE PAIN**, where is it located?

☐ Inside of Knee (closest to opposite knee)
☐ Front of the Knee (under kneecap)
☐ Outside of the Knee
☐ Back of the Knee

Is your PAIN? ☐ Getting Worse ☐ Getting Better ☐ Staying the same

Is your PAIN? ☐ Intermittent ☐ Constant

How would you describe your PAIN?

☐ Sharp ☐ Dull ☐ Throbbing ☐ Tight ☐ Burning ☐ Tingling

Do you have pain when? ☐ Walk ☐ Stand ☐ Sit ☐ At Night

Is your pain worse when? ☐ Walk ☐ Stand ☐ Sit ☐ At Night

Rate your pain (1=minimal, 10= severe pain)? 1 2 3 4 5 6 7 8 9 10

Do you have any of the following? ☐ Stiffness ☐ Swelling ☐ Numbness ☐ Weakness

Do you have a LIMP? ☐ None ☐ Slight ☐ Moderate ☐ Severe

How far can you walk before you start having pain? ☐ Unlimited ☐ 2-3 Blocks ☐ 4-6 Blocks
☐ Indoors Only ☐ Bed to Chair ☐ Unable to Walk

Do you need assistance walking? ☐ Cane ☐ Cane, long walks only ☐ Cane, always
☐ Walker ☐ Wheelchair

Do you have difficult going up or downstairs? ☐ None ☐ Use banisters always
☐ Take a step at a time ☐ Use crutches or cannot do stairs

Do you have difficulty putting on shoes or socks? ☐ None ☐ With difficulty ☐ Unable

Can you sit in a chair comfortably for?
☐Any chair for more than 1 hour ☐ Unable to sit for ½ hour ☐ High chair for ½ hour

Can you get up from a chair? ☐ Normally ☐ Use my arms ☐ Difficulty, even when using arms ☐ Need help, unable to do alone

Have you tried any of the following medications for your pain?
☐ Tylenol ☐ Motrin ☐ Aspirin ☐ Alleve ☐ Vioxx ☐ Celebrex ☐ Other____________________

Have you tried injections? ☐ YES ☐ NO

What kind of injections? ☐ Steroids ☐ Synvisc ☐ Do not know

How many injections? ___________________ When? ____________________

Have you tried physical therapy/exercises? ☐ YES ☐ NO If yes, When? _________

FAMILY HISTORY:

Family Member	Living	Deceased	Age or Age at Death	Health Status/Cause of Death
Father	☐	☐	___________	___________________________________
Mother	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________
Sibling	☐	☐	___________	___________________________________

Do you have children? ☐ YES ☐ NO If yes, how many ____________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Do you exercise regularly? ☐ YES ☐ NO If yes, how many times per week 1 2 3 4 5 6 7

Do you follow a special diet? ☐ YES ☐ NO If yes, describe_____________________

Do you have a family history of blood clots (DVT) or pulmonary embolus? ☐ YES ☐ NO

If yes, please describe ____