Northwestern Medicine®

NMH Preoperative Clinic
259 E. Erie
17th Floor
Chicago, Illinois

NMH Health History Form
Page 1

FOR PHYSICIAN' OFFICE USE ONLY
Physician_____
Procedure Date_____
Fax this completed form to **312-695-6064**

Name
Email Address
Phone Number (Day)
Phone Number (Evening)
Preferred method of contact
Primary care physician
Physician office location
Physician office phone

Date of Birth
Gender ☐Female ☐ Male
Height _____**Weight**
Occupation
Marital Status
Do you need an interpreter? ☐ Yes ☐ No
If so what language?

MEDICAL HISTORY: List all past **surgeries** and **hospitalizations**		
Reason (type of surgery or illness)	at NMH?	Year
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	
	☐	

MEDICATIONS: List all of your medications here or attach a list (Include supplements, vitamins and over the counter medications)		
Name	**Dose**	**# Times/Day**

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?
☐Yes ☐No ☐Unsure

If yes, what type of problem?

3) Do you have any allergies to medications?
☐Yes ☐No

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

4) Are you allergic to latex or other materials?
☐Yes ☐No
If yes, what material and reactions did you have?

5) Have you ever been treated at Northwestern Memorial Hospital before?
☐Yes ☐No

420617

NMH Health History Form Page 2

Name			
Heart/Artery Problems:	☐ Chest pain or angina ☐ Heart attack ☐ Angioplasty or heart stents ☐ Heart surgery ☐ Atrial fibrillation ☐ Heart Failure	☐ Peripheral vascular disease ☐ Blockages in your arteries ☐ Aortic aneurysm ☐ Heart valve disease (not MVP) ☐ Defibrillator (AICD) ☐ Pacemaker	☐ High blood pressure ☐ NONE
Lung Problems:	☐ Emphysema ☐ COPD ☐ Recent pneumonia (last 3 months)	☐ Use of Oxygen at home ☐ Recent TB (tuberculosis) ☐ pulmonary hypertesnsion ☐ Cold or flu in last week	☐ Asthma ☐ NONE
Sleep Problems	☐ Loud snoring ☐ Stop breathing during sleep or have sleep apnea ☐ CPAP		☐ Daytime drowsiness ☐ NONE
Liver or Stomach Problems:	☐ Active Crohn's or Ulcerative colitis ☐ Recent stomach ulcer ☐ Liver transplant	☐ Hepatitis ☐ Cirrhosis	☐ Reflux or GERD ☐ Hiatal hernia ☐ NONE
Urine or Kidney Problems:	☐ Impaired kidney function ☐ Dialysis ☐ Kidney transplant		☐ Bladder infection or UTI ☐ NONE
Gland Problems:	☐ Diabetes ☐ Take prednisone or other steroids	☐ Adrenal problems ☐ Pituitary problems	☐ Thyroid problems ☐ NONE
Brain, Spinal Cord, Nervous System Disease:	☐ Stroke or TIA ☐ MS (multiple scerlosis) ☐ Parkinson's ☐ Brain aneurysm or AVM	☐ Brain tumor ☐ Spinal cord injury ☐ Myasthenia Gravis ☐ Muscular Dystrophy	☐ Seizure disorder ☐ Cerebral Palsy ☐ NONE
Skin Problems:	☐ Active shingles ☐ New rash or open wound		☐ Eczema ☐ NONE
Bleeding or Clotting Disorder:	☐ Hemophilia ☐ Bleeding disorder ☐ Bleed or bruise easily ☐ Sickle Cell Disease	☐ Use of blood thinner medications ☐ Blood clots ☐ Anemia	☐ Family history of bleeding disorder ☐ NONE
Other Issues:	☐ Active leukemia or lymphoma ☐ Multiple Myeloma ☐ Chemotherapy in last 6 weeks	☐ Amyloidosis ☐ HIV	☐ Mood or psychiatric disorders ☐ 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 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 any other significant medical problems? If so, what are they?			

Patient Information	
Patient Name	
Employer Name	
Employer Address	
Employer Phone Number	
Insurance Subscriber	
Subscriber Same as Patient	☐Yes—Skip to the next section ☐No —Complete the next section
Subscriber Name	
Subscriber Date of Birth	
Relationship to Patient	
Employer Name	
Employer Address	
Employer Phone Number	
Local Contact for Day of Surgery	
Contact's Name	
Relationship to Patient	
Preferred Phone number	
Alternate Phone (optional)	