Northwestern Memorial® Hospital

NMH Health History Form
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NMH Preoperative Clinic
233 East Superior Street
Chicago, Illinois 60611
312-926-4343

FOR PHYSICIAN'S OFFICE USE ONLY
Physician _____
Procedure _____
Procedure date _____
FAX this completed form to: **312-440-3812**

Name _____
Email address _____
Phone number (Day) _____
(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	# of 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?
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?
_____
_____
_____

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

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Name_____

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

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 hypertension ☐ 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 sclerosis) ☐ 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 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 for more than 25 years 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?:

_____