Northwestern Medicine®

HEALTH HISTORY

Patient Name _____ Today's Date _____

Date of Birth _____ Preferred Language _____

PHARMACY PREFERENCE

Local Pharmacy Name_____ Town _____ Street_____

PATIENT'S MEDICAL HISTORY *(circle yes or no)*

ADD/ADHD	Yes	No	Blood Transfusion	Yes	No	Foot Problems	Yes	No	Murmur	Yes	No
Alcohol/Drug Abuse	Yes	No	Cancer	Yes	No	Glaucoma	Yes	No	Nerve/Muscle Disease	Yes	No
Allergies	Yes	No	Cataract	Yes	No	High Cholesterol	Yes	No	Osteoporosis	Yes	No
(other than meds)			Circulation Problems	Yes	No	Heart Attack	Yes	No	Pneumonia	Yes	No
Anemia	Yes	No	Colitis/Bowel Disease	Yes	No	Heartburn/GERD/Ulcers	Yes	No	Seizures	Yes	No
Anxiety	Yes	No	Congestive Heart Failure	Yes	No	High Blood Pressure	Yes	No	Sickle Cell	Yes	No
Arthritis	Yes	No	Chronic Obstructive	Yes	No	HIV/AIDS	Yes	No	Stroke	Yes	No
Asthma	Yes	No	Pulmonary Disease			Jaundice	Yes	No	Thyroid Disease	Yes	No
Birth Defect/Genetic	Yes	No	Depression	Yes	No	Kidney Disease	Yes	No	Tuberculosis	Yes	No
Problem			Diabetes	Yes	No	Meningitis	Yes	No	Viral Hepatitis	Yes	No
Blood Clots	Yes	No	Emphysema	Yes	No	Mental Health Problems	Yes	No			

Other Medical History:

PATIENT'S SURGICAL HISTORY *(circle yes or no)*

Abdomen Surgery	Yes	No	Colon Surgery	Yes	No	Hernia Repair	Yes	No
Appendectomy	Yes	No	Cosmetic Surgery	Yes	No	Hysterectomy	Yes	No
Surgical Repair: Broken Bones/Fractures	Yes	No	C-Section	Yes	No	Joint Replacement	Yes	No
Coronary Artery Bypass Graft	Yes	No	Cholecystectomy (Gallbladder)	Yes	No	Ear Tubes	Yes	No
Brain Surgery	Yes	No	Adenoid/Tonsillectomy	Yes	No			
Breast Surgery	Yes	No	Sterilization	Yes	No			

Other Surgical History:

PATIENT'S SOCIAL HISTORY FOR 10 YEARS OLD AND UP

Tobacco Use ☐ Yes ☐ NEVER ☐ Quit ☐ Passive

Packs/Day ☐ .25 ☐ .5 ☐ 1 ☐ 1.5 ☐ 2 ☐ 3

Quit Date

Comment _____

Years of Smoking: ☐ .5 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 10

☐ Other _____

Alcohol Use ☐ Yes ☐ No

Drinks/Week

Glass(es) of Wine

Can(s) of Beer

Shot(s) of Liquor

Drinks Containing 0.5 oz. of Alcohol

Comment _____

Internal Drug Use ☐ Yes ☐ No

Per Week

Comment _____

Types: ☐ Marijuana ☐ Methamphetamines ☐ Cocaine ☐ IV

Sexually Active ☐ Yes ☐ No ☐ Not Currently

Gender of Partners ☐ Female ☐ Male

Comment _____

Birth Control/Protection: ☐ Condom ☐ Pill ☐ Surgical ☐ Spermicide ☐ Rhythm ☐ Injection ☐ Abstinence

Northwestern Medicine®

Please complete the form below relating to your family's medical history.

Place an "X" in the appropriate box below (see example).

PATIENT'S FAMILY HISTORY

Relationship		Name	Status *(Circle)*	Cancer: Type and age of death (if applicable)	Diabetes – Type	Heart Failure	Hypertension (High Blood Pressure)	Asthma	High Cholesterol	Arthritis-Rheumatoid	Arthritis-Osteo	Stroke	Thyroid Disease	Seizures	Migraines	Rashes/Skin Problems	Other _____
Example	**Sister**	**Sally**	**Alive/Deceased**		**X**			**X**				**X**					
Parents	Mother		Alive/Deceased														
Parents	Father		Alive/Deceased														
Siblings			Alive/Deceased														
Siblings			Alive/Deceased														
Siblings			Alive/Deceased														
Siblings			Alive/Deceased														
Siblings			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Patient's Children			Alive/Deceased														
Grandparents	[1]MGM		Alive/Deceased														
Grandparents	[1]MGF		Alive/Deceased														
Grandparents	[2]PGM		Alive/Deceased														
Grandparents	[2]PGF		Alive/Deceased														

1: Maternal
2: Paternal

FEMALE

HEALTH MAINTENANCE	DATE
Last Pap Smear/Gyne Exam	
Last Mammogram	
Last Dexa Scan	
Last Colonoscopy	
Last Tdap/Tetanus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

MALE

HEALTH MAINTENANCE	DATE
Last PSA	
Last Colonoscopy	
Last Tdap/Tetnus	
Last Pneumovax	
Last Flu Shot	
Zostavax	

Do you see other physicians? ☐ Yes ☐ No

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____

Name _____ For what? _____