Northwestern Medicine®

PLACE PATIENT STICKER HERE

Pharmacy Preference

Local pharmacy name ____________________ Town/street ____________________

Mail order pharmacy ____________________ Preferred language ____________________

Medical History (Circle yes or no)

Condition		
Asthma	Yes	No
Chronic obstructive pulmonary disease (COPD)	Yes	No
Sleep apnea	Yes	No
Diabetes	Yes	No
Kidney disease	Yes	No
Liver disease	Yes	No
Osteoporosis	Yes	No
Cancer	Yes	No
Skin cancer	Yes	No
Seizures	Yes	No
High blood pressure	Yes	No
High cholesterol	Yes	No
Heart problems	Yes	No
Congestive heart failure (CHF)	Yes	No
Blood clots	Yes	No
Transient ischemic attack (TIA)	Yes	No
Stroke	Yes	No
Anxiety	Yes	No
Depression	Yes	No
Bipolar	Yes	No
Schizophrenia	Yes	No

Other ____________________

Surgical History

	Circle below		Date
Appendix removal	Yes	No	________
Gallbladder removal	Yes	No	________
Thyroid removal	Yes	No	________
Tonsil removal	Yes	No	________
Cataract removal	Yes	No	________
Hysterectomy	Yes	No	________
Tubal ligation	Yes	No	________
Ovary removal	Yes	No	________
Breast removal	Yes	No	________
	Right/Left		
Breast biopsy	Yes	No	________
Hernia repair	Yes	No	________
Gastric restriction surgery	Yes	No	________
Heart bypass surgery (CABG)	Yes	No	________
Hip surgery-replacement	Yes	No	________
	Right/Left		

	Circle below		Date
Knee surgery-arthroscopic	Yes	No	________
	Right/Left		
Knee surgery-replacement	Yes	No	________
	Right/Left		
Spinal surgery	Yes	No	________
Type:			
Implant	Yes	No	________
Type:			
Transplant	Yes	No	________
Type:			
Stent placement	Yes	No	________
Location:			

Other ____________________

Continued >

Health Questionnaire (continued)

PLACE PATIENT STICKER HERE

Health Maintenance

Indicate most recent dates of completion if applicable

Last Tdap/Tetanus		Last Colonoscopy	
Last Pneumovax		Last Pap Smear/Gyne Exam	
Last Flu Shot		Last Mammogram	
Shingrix		Last Dexa Scan	

Family Health History

Check all that apply

	Alive (Y or N)	No known problems	Cancer	Breast cancer	Uterine cancer	Ovarian cancer	Prostate cancer	Colon cancer	Coronary artery disease	Stroke	High blood pressure	Diabetes	High cholesterol	Thyroid disease	Asthma	Rheumatoid	Migraines
Mother																	
Father																	
Sister																	
Sister																	
Brother																	
Brother																	
Maternal Grandmother																	
Maternal Grandfather																	
Paternal Grandmother																	
Paternal Grandfather																	
Other																	

☐ Adopted ☐ Family history unknown

Continued >

Health Questionnaire (continued)

PLACE PATIENT STICKER HERE

Social History

Circle, check or fill in as applicable

Tobacco use

☐ Never
☐ Former smoker
☐ Current smoker
☐ Passive smoke exposure

Packs per day: 0.25 0.5 1 1.5 2 3

Type(s): Cigarettes Pipe Cigars E-cigarettes

Start date: ____________

Quit date: ____________

Years: 0.5 1 2 3 4 5 10 15

Smokeless tobacco use

☐ Never
☐ Current
☐ Former

Type(s): Chew Snuff

Alcohol use

☐ Yes
☐ No
☐ Not currently

Drinks per week: ____________

Glasses of wine: ____________

Cans of beer: ____________

Shots of liquor: ____________

Substance/drug use

☐ Yes
☐ No
☐ Not currently

Type(s):
☐ Marijuana
☐ Cocaine
☐ Inhalant
☐ Prescription pain medication
☐ Heroin
☐ Methamphetamine
☐ Hallucinogenic
☐ Prescription stimulant

Sexually active

☐ Yes
☐ No
☐ Not currently

Partners: Female Male Trans Female Trans Male Other

Birth control/protection

☐ Condom
☐ Pill
☐ IUD
☐ Ring
☐ Spermicide
☐ Rhythm
☐ Injection
☐ Abstinence
☐ Surgical
☐ Treatment as prevention: Pre-exposure prophylaxis

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