



## Northwestern Medical Faculty Foundation

---

William J. Catalona, MD  
Department of Urology  
675 North St. Clair Street  
Suite 20-150  
Chicago, IL 60611  
Tel(312) 695-8146  
Fax(312) 695-1144  
Email watalona@nmff.org

Dear Patient:

The Department of Urology at Northwestern Medical Faculty Foundation and Northwestern Memorial Hospital **require** you to complete the attached Patient Health Survey, prior to proceeding with your scheduled surgical procedure. Please complete the attached patient health history questionnaire and return it to me at the address below. Also, you have the option of faxing the form to 312-695-1144 or returning as an email attachment to the address provided below.

After receiving your completed form I will be able to move forward with your scheduled surgical procedure.

It is **imperative** we receive this form **AS SOON AS POSSIBLE**, so your surgery procedure is not delayed or cancelled.

Thank you for your attention to this matter,

Sanjina Shrestha, RN and Carolina Sanchez, LPN.  
Dr. William J. Catalona  
Northwestern Medical Faculty Foundation  
Department of Urology  
675 North St. Clair Street, Suite 20-150  
Chicago, Illinois 60611  
Tel (312) 695-6126 Fax (312) 695-1144  
Email: [sshresth@nmff.org](mailto:sshresth@nmff.org) or [csanchez@nmff.org](mailto:csanchez@nmff.org)

\*\*\*\*Complete **only** if you are scheduled for surgery!!!!\*\*\*\*\*



**NMH Health History Form Page 2**

Name \_\_\_\_\_

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

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

<b>Employment Status</b>	<b>Full time</b> <input type="checkbox"/> <b>Part-time</b> <input type="checkbox"/> <b>Unemployed</b> <input type="checkbox"/>
	<b>Self employed</b> <input type="checkbox"/> <b>Retired</b> <input type="checkbox"/>

<b>Employer/Company Name:</b>	
<b>Employer/Company Address:</b>	
<b>Telephone #:</b>	<b>Ext:</b>
<b>Fax#:</b>	
<b>Contact Person:</b>	

<b>If retired, Please list at what age you retired?</b>	
---	--

**\*\*\* Please fax the front of back of your insurance card with this form to 312-695-1144, ATT: Carolina Sanchez \*\*\*\*\***