Northwestern Medical Faculty Foundation

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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
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Chicago, Illinois 60611
Tel (312) 695-6126 Fax (312) 695-1144
Email: sshresth@nmff.org or csanchez@nmff.org

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

Northwestern Memorial® Hospital

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

NMH Health History Form
Page 1

FOR PHYSICIAN'S OFFICE USE ONLY
Physician _____
Procedure _____
Procedure date _____
FAX this completed form to: **312-926-9081**

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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NMH Health History Form Page 2

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?:

_____

Employment Status	**Full time** ☐ **Part-time** ☐ **Unemployed** ☐ **Self employed** ☐ **Retired** ☐

Employer/Company Name:	
Employer/Company Address:	
Telephone #: **Fax#:**	**Ext:**
Contact Person:	

If retired, Please list at what age you retired?	

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