Northwestern Memorial® Physicians Group

Corporate Health Services
676 North Saint Clair
Suite 900
Chicago, Illinois 60611
www.nmpg.com

HEALTH HISTORY

Please complete the following questionnaire to your best ability; your answers will be used by a Corporate Health provider to assess your overall health. Any information you provide will be kept confidential; nothing from this questionnaire will be shared with your current or potential employer.

Do you have trouble understanding spoken or written English? (If yes, please inform the receptionist now) ☐ No ☐ Yes

Do you have any religious or cultural beliefs that could affect your care during today's visit? ☐ No ☐ Yes

Have you ever been employed by Northwestern Memorial Hospital or any of its affiliates? ☐ No ☐ Yes
(If yes, when? [years]: __________)

PLEASE PRINT

LAST NAME	FIRST NAME	MIDDLE NAME	TODAY'S DATE
STREET ADDRESS & UNIT	CITY / STATE / ZIP		HOME PHONE
DATE OF BIRTH (MM/DD/YYYY)	AGE / MARITAL STATUS / SEX		SOCIAL SECURITY NUMBER
PERSONAL PHYSICIAN	PHYSICIAN'S CITY		DATE OF LAST TETANUS SHOT
NEW JOB TITLE	NAME OF NEW EMPLOYER		

PLEASE LIST ALL OF YOUR CURRENT:

MEDICATIONS, INCLUDING VITAMINS: ____

____

HERBAL SUPLEMENTS OR HOMEOPATHIC PREPARATIONS: ____

ALLERGIES (FOOD AND DRUG): ____

Are you allergic to LATEX? ☐ No ☐ Yes If yes, what are your symptoms? ______________________________

Please answer each of the following questions; If you answer "YES" to any of the items, please provide necessary details.

HEALTH HISTORY	YES	NO	IF YES, PLEASE PROVIDE DETAILS
1. Have you had any surgeries or operations:			
a. On your back, arms, legs, or knees?			
b. To treat a hernia?			
c. During or concerning childbirth?			
d. Any others not mentioned?			
2. Have you ever been hospitalized?			
3. Have you ever had, or do you currently have:			
a. Any serious allergies?			
b. A bad reaction to medications (including vaccines)?			
c. Medical advice not to take a certain medication?			
4. Have you ever had, or do you currently have the following SKIN conditions:			
a. Hives, eczema, rash?			
b. Chronic skin problems?			
c. Excessive skin dryness?			
d. Rash/sensitivity to chemicals or jewelry?			
e. Frost bite?			

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HEALTH HISTORY (Continued)	YES	NO	IF YES, PLEASE PROVIDE DETAILS
5. Have you ever had, or do you currently have the following SLEEP conditions:			
a. Snoring issues?			
b. Tiredness after a full night of sleep?			
c. Trouble staying awake during the day?			
6. Have you ever had, or do you currently have the following NEUROLOGICAL conditions:			
a. Psychiatric conditions or emotional inconsistencies?			
b. Numbness, weakness, or paralysis?			
c. Dizziness or fainting spells?			
d. Severe or frequent headaches, including migraines?			
e. Head injury or skull fracture?			
f. General neurological disorders?			
g. Seizures or blackouts?			
h. Stroke?			
i. Other conditions not listed?			
7. Have you ever had, or do you currently have any of the following EAR conditions:			
a. Hearing loss?			
b. Frequent ear infections?			
c. Ringing in the ears?			
d. Other ear problems not listed			
8. Have you ever had, or do you currently have any of the following EYE conditions?			
a. Glaucoma or cataracts?			
b. Chronic red or dry eyes?			
c. Eye injury (with or without vision loss)?			
d. Do you wear corrective lenses?			
e. Other eye conditions not listed?			
f. Have you ever had a vision screen? (If yes, please provide the date.)			
9. Have you ever had, or do you currently have any of the following MAXILLOFACIAL conditions?			
a. Problems with teeth (Decay, pain, etc.)?			
b. Oral lesions, ulcers, or infections?			
c. Have you ever had a dental exam? (If yes, please provide the date.)			
d. Chronic sinus infections or hay fever?			
e. Frequent sore throats or strep throat?			
f. Frequent nose bleeds?			
g. Thyroid conditions?			
h. Conditions requiring radiation to the maxillofacial region?			

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HEALTH HISTORY (Continued)	YES	NO	IF YES, PLEASE PROVIDE DETAILS
10. Have you ever had, or do you currently have any of the following LUNG conditions?			
a. Asthma or wheezing?			
b. Coughing with blood production?			
c. Chronic shortness of breath without reason?			
d. Tuberculosis (TB) or a positive TB test?			
e. Pneumonia or pleurisy?			
f. Chronic, daily cough with morning concentration?			
g. Pain or tightness in chest?			
h. More than three (3) episodes of bronchitis occurring within one year?			
i. Have you ever had a chest x-ray? If so, please provide date.			
11. Have you ever had, or do you currently have any of the following CARDIOVASCULAR conditions?			
a. Heart murmur or rheumatic fever?			
b. Heart disease?			
c. Chest pain following strenuous activity?			
d. Have you ever been treated for a heart condition?			
e. Unusually cold or blue colored hands or feet?			
f. High blood pressure? If yes please specify how it is being treated.			☐ Medication ☐ Diet ☐ Exercise ☐ None
g. Do you have a history of high cholesterol?			
h. Anemia or any blood disease?			
i. Phlebitis?			
j. Varicose veins?			
k. Blood clots?			
l. Poor circulation?			
12. Have you ever had, or do you currently have any of the following GASTROINTESTINAL conditions?			
a. Ulcers, indigestion, pain or burning in stomach?			
b. Hiatal hernia or GERD?			
c. Vomiting with or without blood?			
d. Blood/tarry bowel movements?			
e. Diarrhea from infection? (e.g. Salmonella)			
f. Frequent loose bowel movements?			
g. Colitis or nervous stomach?			
h. Jaundice or hepatitis?			
i. Pancreatic disease?			
j. Gallbladder disease?			
k. Hernia?			
13. Have you ever had, or do you currently have any of the following URULOGICAL conditions?			
a. Bladder or kidney infections?			
b. Kidney stones?			
c. Burning or discomfort during urination?			
d. Frequent urination?			
e. Blood in urine?			

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HEALTH HISTORY (Continued)	YES	NO	IF YES, PLEASE PROVIDE DETAILS
14. Have you ever had, or do you currently have any of the following MUSCULAR/SKELETAL conditions?			
a. Arthritis or rheumatism?			
b. Back or neck problems requiring treatment?			
c. Recurrent back or neck problem?			
d. Bursitis or tendonitis?			
e. Broken bones?			
f. Recurrent pulled muscles or sprains?			
g. Any hand or wrist injuries or problems, including carpal tunnel syndrome?			
h. Any joint problems?			
15. Miscellaneous			
a. Do you have diabetes?			
b. Do you currently or have you ever had cancer of any type?			
c. Have you ever been vaccinated against tetanus? If yes, please give the date of your last dose.			
d. Have you been vaccinated against Hepatitis B?			
e. Are there any medical conditions that you have currently or had in the past that have not otherwise been mentioned? Please provide details if so.			
16. FEMALES ONLY: Have you ever had, or do you currently have any of the following conditions?			
a. Menstrual irregularities?			
b. Recurrent problems of the uterus or ovaries?			
c. Breast masses or lumps?			
d. Do you practice monthly breast self-exams?			
e. Have you ever had a mammogram?			
f. Date of last pap smear?			
17. MALES ONLY: Have you ever had, or do you currently have any of the following conditions?			
a. Prostate or testicular problems?			
b. Breast tenderness, swelling, or lumps?			
c. Do you practice monthly testicular self-exams?			

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The questions below this point refer to your current and sometimes past lifestyle choices; Please answer each of the following questions; If you answer "YES" to any of the items, please provide necessary details.

LIFESTYLE	YES	NO	IF YES, PLEASE PROVIDE DETAILS
18. Do you participate in any of the following activities?			
a. The use of recreational drugs? If yes, how many times a week?			☐ 1-5 ☐ 6-10 ☐ 11-15 ☐ 16 or more
b. The use of over-the-counter medications on a regular basis? If yes, please list types and frequency.			
c. Do you ever feel guilty about the amount you drink or your actions under the influence of alcohol?			
d. Have you ever needed an "eye opener" (a drink in the morning)?			
e. Have you ever used tobacco in any form?			How Long? ________yrs Pack/Day_____ When Quit______
f. Do you exercise 3 times per week? (30-40 minutes each time)			
g. Are you more than 30% above your ideal weight?			
h. Hobbies such as furniture refinishing, painting, hunting, shooting, or model building?			
19. Do the following work-related health situations apply to you?			
a. Have you ever been given work restrictions or been placed on "light duty" because of your health or an injury?			
b. Have you ever left a job because of health problems?			
c. Have you ever been injured on the job to the extent that medical treatment is necessary?			
d. Have you ever received compensation for a work-related injury or illness?			
e. Are you currently receiving any ongoing medical treatment (i.e. physical therapy, chiropractic, acupuncture, medical, etc)?			
f. Do you moonlight or have a second job? If yes, please describe.			

Please list your prior work history, starting with the most recent job first.

Date (Year to Year)	Employer	Position	Any Job-Related Hazards or Chemical Exposures

NOTE: The following questions pertain to your biological relatives; your mother, father, and any siblings. If you are unsure of the health history for one or more of these people, please indicate so.

	Date of Birth	Deceased?	If deceased, please provide year and cause of death
Mother		**Y N**	
Father		**Y N**	
Sibling 1 Circle: Brother Sister		**Y N**	
Sibling 2 Circle: Brother Sister		**Y N**	
Sibling 3 Circle: Brother Sister		**Y N**	
Sibling 4 Circle: Brother Sister		**Y N**	
Sibling 5 Circle: Brother Sister		**Y N**	

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Have your direct family member ever experienced, or are they currently experiencing, any of the following illnesses or events? If no, leave the box blank; If yes, check the appropriate box and list the age at which the event/illness occurred.

	Mother		**Father**		**Brother/Sisters**	
	√					
Heart Attack						
Heart Surgery						
Heart Disease						
Stroke						
High Blood Pressure						
High Cholesterol						
Diabetes						
Obesity						
Asthma						
Cancer						
Kidney or Liver Disease						
Lung Disease						
Tuberculosis (TB)						
Psychiatric Disorder						
Alcohol/Drug Problems						
Inherited Disease						

I certify that the above information is true and complete to the best of my knowledge. I hereby give NMPG Corporate Health Services the permission to release only work related information to the proper authorities of my employer or the company for which I am a job applicant.

I hereby authorize the NMPG Corporate Health Services physician or his/her designee to perform a physical examination, provide any necessary treatment, and report to my current/prospective employer my physical qualifications to perform my job duties.

Patient's Signature: ______________________________ Date: ______________

Examiner's Signature: ______________________________ Date: ______________