Northwestern Medicine®

PLACE PATIENT STICKER HERE

Pharmacy Preference

Local Pharmacy Name _____ Town/Street _____

Mail Order Pharmacy _____ Preferred Language _____

Medical History (Circle Yes or No)

Asthma ..... Yes No

Chronic Obstructive Pulmonary Disease (COPD) ..... Yes No

Diabetes ..... Yes No

Kidney Disease ..... Yes No

Osteoporosis ..... Yes No

Cancer ..... Yes No

Skin Cancer ..... Yes No

Seizures ..... Yes No

High Blood Pressure ..... Yes No

Sleep Apnea ..... Yes No

Liver Disease ..... 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 yes or no)

		Date
Appendix Removal	Yes No	
Gallbladder Removal	Yes No	
Thyroid Removal	Yes No	
Tonsil Removal	Yes No	
Tubal Ligation	Yes No	
Ovary Removal	Yes No	
Breast Removal	Yes No	
Right/Left		
Breast Biopsy	Yes No	
Hernia Repair	Yes No	
Heart Bypass Surgery (CABG)	Yes No	

		Date
Knee Surgery – Arthroscopic	Yes No	
Knee Surgery – Replacement	Yes No	
Spinal Surgery	Yes No	
Type:		
Implant	Yes No	
Type:		
Transplant	Yes No	
Type:		
Stent Placement:	Yes No	
Location:		
Other		

Limb Restrictions: Yes No If yes, what restrictions/Laterality

Gender Identity (Circle one) Female Male Non-Binary Transgender Female Transgender Male Other Choose not to Disclose

PLACE PATIENT STICKER HERE

Health Questionnaire (Continued)

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
Mother																
Father																
Sister																
Sister																
Brother																
Brother																
Maternal Grandmother																
Maternal Grandfather																
Paternal Grandmother																
Paternal Grandfather																
Other																

Social History (Circle, check, or fill in all that apply)

Tobacco Use

- ☐ Never
- ☐ Former Smoker
- ☐ Current Smoker Everyday
- ☐ Current Smoker Somedays
- ☐ Passive Smoke Exposure

Packs per day: 0.25 0.5 1 1.5 2 3

Type(s): Cigarettes Pipe Cigars

Start Date: _____

Quite Date: _____

Years: 0.5 1 2 3 4 5 10 15

E-Cigarettes/Vaping

- ☐ Never
- ☐ Former
- ☐ Current Smoker Everyday
- ☐ Current Smoker Somedays

Type(s): Nicotine THC CBD Flavoring

Other: _____

Start Date: _____

Quite Date: _____

Packs/Day: _____

Years: 0.5 1 2 3 4 5 10 15

Alcohol Use

- ☐ No
- ☐ Yes
- ☐ Not Currently

Type(s): Beer Wine Liquor

Drinks per week: _____

Glasses of wine: _____

Cans of beer: _____

Shots of liquor: _____

Smokeless Tobacco Use

- ☐ Never
- ☐ Current
- ☐ Former

Type(s): Chew Snuff

Substance/Drug Use

- ☐ Yes
- ☐ Never
- ☐ Not Currently

Type(s): Amphetamines Anabolic steroids Barbituates Benzodiazepines Cocaine Codeine Fentanyl Hallucinogenic Heroin Hydrocodone Inhalants Marijuana MDMA (Ecstasy) Methamphetamine Prescription Pain Medication Prescription Stimulant

Other: _____

Sexually Active

- ☐ Yes
- ☐ No
- ☐ Not Currently

Partners: Female Male Trans Female Trans Male Other: _____

How often are you using condoms: _____% of the time.

Birth Control/Protection

- ☐ Abstinence
- ☐ Cervical Cap
- ☐ Coitus Interruptus
- ☐ Condom
- ☐ Diaphragm
- ☐ I.U.D.
- ☐ Implant
- ☐ Injection
- ☐ None
- ☐ Patch
- ☐ Pill
- ☐ Ring
- ☐ Spermicide
- ☐ Surgical
- ☐ TAsP (Treatment as prevention)
- ☐ PrEP (Pre-Exposure Prophylaxis)
- ☐ Other: _____