

HEALTH HISTORY

Please complete the following questionnaire to you 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 SUPPLEMENTS 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?			

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?			

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.			<input type="checkbox"/> Medication <input type="checkbox"/> Diet <input type="checkbox"/> Exercise <input type="checkbox"/> 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?			

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?			
g. Infection of the female reproductive organs?			
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?			
d. Infection of the male reproductive organs?			

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?			<input type="checkbox"/> 1-5 <input type="checkbox"/> 6-10 <input type="checkbox"/> 11-15 <input type="checkbox"/> 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?			

I certify that the above information is true and complete to the best of my knowledge.

I hereby authorize the NMPG Corporate Health Services physician or his/her designee to perform a physical examination and provide any necessary treatment or testing.

Patient's Signature: _____

Date: _____

Examiner's Signature: _____

Date: _____

Immigration Health History Supplemental Questionnaire

You are asked to complete this additional questionnaire to help classify your TB status for immigration purposes.

Name: _____

Date of Birth: _____

1. How long have you resided in the United States? _____
2. Are you presently taking steroid medications or medications for diabetes? _____
3. Do you have a history of any of the following?
 - Gastrointestinal Bypass
 - Kidney Disease
 - Cancer including Leukemia or head/neck cancer
 - Organ Transplant
 - HIV
 - Silicosis
4. Has anyone in your family or have any of your friends been diagnosed with TB? _____
5. Do you work or reside in a hospital, nursing home, or homeless shelter? _____
6. Do you have any of the following symptoms?
 - Loss of appetite
 - Night sweats
 - Weight loss
 - Fever
 - Easily fatigued

Patient Name _____ **Patient Signature** _____ **Date** _____

Physician _____ **Physician Signature** _____ **Date** _____