Northwestern Medicine®

1800 N. Main Street
Wheaton, IL 60187
630.614.4960
Fax: 630.682.3727
Cadencephysiciangroup.com

Medical History Form

Name:_____; Birth date: ___/___/___; Date: ___/___/___

Person filling out form: _____; Relationship: _____

Thank you for taking the time to fill out this valuable information. This allows us to provide the best care possible to our patients. Feel free to use additional pages to write any information not included here that you think is important.

Main reason for visit: _____

1. Current/Past Medical Problems: Example Strokes, Heart trouble, High Blood Pressure, High Cholesterol, Thyroid Problems, Eye problems, etc.

Current or Past Medical Problem	Approximate date of onset or diagnosis
1.	
2.	
3.	
4.	
5.	
6.	
7.	

2. Past Surgeries: Example Gall Bladder removed, Appendectomy, Hysterectomy with or without ovaries removed, Cataract surgery, Prostate surgery, Heart surgery, Angioplasty, Colonoscopy, etc.

Past Surgery	Approximate Date of Surgery
1.	
2.	
3.	

3. Medical Allergies and reaction: Example rash, swelling, trouble breathing, etc.

Medicine Allergic To	Reaction
1.	
2.	
3.	

4. Medications: Please list both prescription and over the counter medication (such as pain relievers, constipation medicine, heart burn medicine, vitamins, etc.) and how many times a day medication is taken. For as needed medication please give an estimate of how often you take it such as once every other day, once a week, once or twice a month, etc. Add another sheet with additional medications if necessary.

Medication and Strength (mg or mcg, etc.)	How Often Taken or As Needed
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	
11.	
12.	
13.	
14.	
15.	

5. Local Pharmacy: _____; Phone #: _____
Mail Order Pharmacy: _____; Phone #: _____
Member ID #: _____; Fax #: _____

6. Family History: Please list medical problems of close family members (example Dementia, Cancer and what type, Heart disease, Stroke, Diabetes, Hypertension, Depression, etc.), if anyone has died, the age of death and the cause of death. **Underneath "Mother" list any brother(s)/sister(s) and their medical problems.**

Family Member	Age Died	Cause of Death or any Medical Problems
Father		
Mother		
Brother		
Sister		

7. Social History:

- **Tobacco Use:** Never□; Quit□ ; Current Smoker□.
  Packs per day on average: _____; Years smoked: _____;
  Quit Date: _____; Type; Cigarette□; Cigar□; Pipe□.
- **Smokeless Tobacco:** Current User□; Former User□; Never Used□; Unknown□.
- **Alcohol Use:** None□**;** Number of drinks per week_____?
  Was drinking too much alcohol ever a problem for you? Yes□; No □
- **Illegal Drug Use:** No □**;** Yes □**;** Type **_____**
- **Sexual Activity:** Not currently □; No □; Yes □
- Describe who cares for patient_____
- Tell us something the patient is proud of in their lifetime_____
  _____
  _____
  _____
- **Past Occupation:**_____; Years of Education_____
- **Advance Directives:** Durable Power of Attorney for Healthcare □
  Name and relationship_____;
  Living Will□; Do Not Resuscitate Form□; would you like information on Advanced Directives Yes□; No □
- **Religion/Faith:** _____; is your faith important to you and does it affect your health care decisions: _____
  If you have any of the above documents please have a copy of them made for us to place in their chart.

8. Activities of Daily Living: Please mark or fill in the appropriate box below.

Activities of Daily Living	No Assistance	Total Assistance	Needs Some Partial Assistance: Please Describe
Feeding			
Bathing			
Toileting			
Dressing			
Transferring			
Walking			

9. Review of Systems: Please check or describe below any of the following symptoms You may be having:

- **General:** Fever □; Chills □; Weight loss □; Fatigue □; Sweating □; Weakness □
- Height: _____Feet _____inches; Any loss of height: _____inches
- Weight: _____pounds (Can estimate); Please list weight loss _____ pounds over the past _____ months.
- **Skin:** Rash □ ; Location: _____; Itching □; Bed sore □;
- Location of bedsore and type of dressing_____
- **Head:** Headaches □; Hearing loss □; Hearing aide □; Ringing in ears □; Ear pain □; Ear discharge□; Nose bleeds□; Nose congestion□; Sore throat□; Last Dental exam_____
- **Eyes:** Blurred Vision □; Double Vision □; Light Sensitivity □; Eye pain □; Eye discharge□; Eye Redness□; Last eye exam: _____
- **Heart:** Chest pain □; Palpitations □; Trouble breathing lying flat □; Leg cramps □; Leg swelling □
- **Lungs:** Cough □; Sputum production □; Shortness of breath □; Wheezing □; On Oxygen□; Oxygen flow rate_____
- **Gastrointestinal:** Heart burn □; Nausea □; Vomiting □; Abdominal pain □; Diarrhea □; Constipation□; Blood in stool □
- **Genitourinary:** Urinary burning □; Urgency □; Frequency □; Blood in urine□; Incontinence□;
- **Musculoskeletal:** Muscle aches □; Neck pain □; Back pain □; Joint pain □ (Location: _____); Falls□;
- **Endocrine:** Easy bruising □; Environmental allergies □; Extreme thirst □; If diabetic Morning sugar range _____, Evening sugar range_____
- **Neurological:** Dizziness □; Tingling □; Tremor □; Sensory change □; Speech change □; Difficult/Trouble swallowing □; Weakness on one side of body from stroke □; Seizures□; Loss of consciousness□;
- **Psychiatric:** Depression □; Suicidal thoughts □; Substance abuse □; Hallucinations □; Nervous/Anxious □; Insomnia □; Memory loss □;

10. Immunizations: Please mark the appropriate box below and list dates if known. **If not known please contact your primary care doctor before our visit and ask if you are Up-to-date on your immunizations.**

Immunization	Yes	Date	No	Unknown	Refuses
Influenza (Flu)					
Pneumovax (Pneumonia)					
Prevnar					
Tetanus					

11. Durable Medical Equipment: Please list any medical equipment you have in the home such as a bedside commode, wheel chair, walker, hospital bed, tube feeding pump, suction machine, etc. Please also list the name of the medical supplier and their phone number.

Name of Equipment	Supplier Name	Supplier Phone #
1.		
2.		
3.		
4.		
5.		

12. Home Health Agency: Yes□**;** No□**; Name: _____;**
Phone #: _____; Nurse: Yes□**;** No□**; Physical therapy:** Yes□**;** No□**;**
Occupational Therapy: Yes□**;** No□**; Speech Therapy:** Yes□**;** No □

13. Recent Hospitalizations: Please list the reason for any recent hospitalizations in the past 2 years and the hospital you were in.

Reason for Hospitalization	Name of Hospital	Date
1.		
2.		
3.		
4.		

14. Recent Doctors: Please list any recent doctors, their specialty (e.g. Primary doctor, cardiologist, neurologist, etc.) and their phone number and fax number.

Doctor Name	Specialty	Phone	Fax
1.			
2.			
3.			

Please fax this information to HomeCare Physicians' office at 630-682-3727 or mail it (address on first page) prior to the first visit.