150 N. River Rd. Ste 310
Des Plaines, IL 60016
Tel: 847.795.0900
Fax: 847.795.0955

NORTH SUBURBAN
Family Medicine

7447 W. Talcott Ave. Ste 363
Chicago, IL 60631
Tel : 773.763.1344
Fax : 773.763.4313

Patient Health History Form (Please Print)

Today's Date: _____

Patient Name:	Date of Birth / /	Spouse/Significant Other:

Please list other household members below: include name, age and relation

_____
_____
_____

Patient Health History

Check all items either Yes or No	No	Yes, Now	Yes, Past	Check all items either Yes or No	No	Yes, Now	Yes, Past
Abnormal EKG				Head injury			
Alcoholism				Headaches (frequent)			
Allergies or hay fever				Heart attack or disease			
Anemia or low blood count				Heart murmur			
Anxiety				Hemorrhoids or other rectal			
Arthritis or sore joints				Hepatitis Type A, B or C (Circle)			
Asthma				Hernia			
Bleeding or bruising easily				High Blood Pressure			
Broken bones				High Cholesterol			
Bronchitis or Emphysema				HIV/Aids			
Cancer				Jaundice			
Cataracts				Kidney or Bladder issues			
Chemical dependency				Leg or foot pain			
Chest pain				Liver disease			
Circulation problems				Night sweats			
Deafness or ringing in ears				Phlebitis or blood clots			
Depression or Sadness				Psychiatric care			
Diabetes				Sexually Transmitted Disease			
Difficulty sleeping				Shortness of breath			
Dizziness				Sinus trouble			
Ear infections				Skin disease/Psoriasis/Eczema			
Epilepsy or Seizures				Stomach issues or Ulcers			
Fatigue/Tiredness/Weakness				Stool or Bowel issues			
Forgetfulness				Stroke			
Gall Stones				Thyroid problem			
Glaucoma				Tuberculosis or Positive TB Test			
Gout				Weight loss or gain (circle one)			

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Please list prior surgeries or hospitalizations (including year):

1._____ 2._____

3._____ 4._____

5._____ 6._____

Health Maintenance – Please list most recent month/year of each (if known):

Flu Vaccine: _____ Pneumococcal Vaccine: _____ Tetanus: _____

Stress Test: _____ PAP Test: _____ Mammogram: _____

Last Menstrual Period: _____ Colonoscopy: _____ PSA (Prostate): _____

Medications (include over the counters, herbals, supplements & vitamins):

Name of Medication	Dose	Directions

Allergies (medications, foods, environmental). Please include what reaction you may have:

1._____ 2. _____

3. _____ 4._____

Social History:

Are you: ☐ Single ☐ Married ☐ Partner/Significant Other ☐ Divorced ☐ Widowed

Your Occupation: _____ Your Employer: _____

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Do you smoke? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Type:	Packs/day:	For how many years:

Do you drink alcohol? ☐ Yes ☐ No Are you interested in quitting? ☐ Yes ☐ No

Type(s):	Drinks per day:	Drinks per week:

Do you use illicit drugs? ☐ Yes ☐ No Have you used illicit drugs in the past? ☐ Yes ☐ No

Type(s):	Route:	Amount:	Frequency:	Last use:

Do you have concerns regarding eating disorders? ☐ Yes ☐ No

Do you have concerns regarding domestic violence? ☐ Yes ☐ No

Family History

Please list relationship, age at diagnosis and if deceased, age at time of passing					
Issue	Relation	Age	Issue	Relation	Age
Heart Disease			High Blood Pressure		
Heart Failure			High Cholesterol		
Stroke			Aneurysm		
Poor Circulation			Amputation		
Emphysema			Asthma		
COPD			Chronic Bronchitis		
Cancer (type)			Oxygen (Home use)		
Diabetes			Thyroid Disease		
Liver Disease			Hepatitis (type)		
Kidney Disease			Kidney Failure		
Dementia			Arthritis (type)		
Other			Other		

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Review of Symptoms

Please circle all the symptoms that you have been experiencing:

Cardiac: Chest pain, palpitations, pressure in the chest, heaviness in the chest, heart murmur

Lungs: Shortness of breath, chronic cough, coughing up blood, wheezing

GI: Nausea, vomiting, diarrhea, chronic constipation, hemorrhoids, abdominal pain, heartburn, blood in your stool, black tarry stools, pelvic pain, indigestion, acid reflux

GU: Difficulty urinating, blood in your urine, pain when urinating, urinary incontinence, bedwetting, frequent urination, waking at night to urinate, daytime wetting

Reproductive: Penile discharge, vaginal discharge, vaginal itching, heavy/painful/irregular periods

Age of first period: _____ Date of last menstrual period: _____

Muscular: Swelling in legs, chronic back pain, recurrent back pain, muscle aches, muscle deformity, joint pain (where?_____)

Skin: Lumps, bumps, moles of concern, rash, sores/lesions

Neurological: Numbness, tingling, tremor, seizure, convulsions, headaches (migraine, tension, cluster, sinus)

Eyes: Vision loss, blurred vision, double vision, blindness

I wear (please check): Glasses _____ Contacts _____ to (circle) Drive / Read / All the time

Ears: Hearing loss, vertigo, ringing, hearing aid (right / left / both), failed hearing screening

Nose: Bloody nose, obstruction, deviated septum, snoring, post nasal drip

Throat: Sore throat, lump in throat, change in voice, difficulty swallowing

Psych: Depressed, moody, anxiety, panic attacks, hallucinations, tearfulness, lack of motivation

General: Fever, chills, weight loss, weight gain, fatigue, lack of energy, change in appetite, change in sleep

Other: _____

_____

_____

Thank you for taking a few moments to complete this medical history form 😊