NorthShore
University HealthSystem

Medical Group

Glenbrook Comprehensive Care Center

Glenbrook South Professional Building
2050 Pfingsten, Suite 200
Glenview, IL 60026

Phone (847) 503-2222
Fax (847) 503-2228

NEW PATIENT QUESTIONNAIRE

Please do your best to answer all questions. Thank you.

Name:_____ DOB:_____ Date: _____

Who referred you to this office? _____

Reason for this visit: _____

_____

_____

List your most troublesome symptoms:_____

_____

_____

Recent physicians you have been seeing (primary care and specialists):

Primary Care: _____

Specialty: _____ Name: _____

Specialty: _____ Name: _____

Specialty: _____ Name: _____

Eye Doctor:_____ Dentist:_____

☐ Check here if you see additional physicians (enter details at the end of this form)

RECENT CARE

When did you last see a doctor?_____

For what reason? _____

When were you last hospitalized?_____

What were you hospitalized for? _____

Were you seen in the Emergency Room for any reason over the past 12 months? Yes / No

If yes, for what reason?_____

Marital status:
☐ Single ☐ Married ☐ Separated ☐ Partnered ☐ Divorced ☐ Widowed

Do you have children? Yes ☐ No ☐

If yes, please provide additional details:

Name Birthdate Where do they live?

Do you have any grandchildren? Yes ☐ No ☐ How Many?_____

Do you have any great grandchildren? Yes ☐ No ☐ How Many?_____

Check the type of place you live:

☐ House ☐ Apartment ☐ Condominium ☐ Independent Living Community
☐ Assisted Living Facility ☐ Supportive Living Facility
☐ Other (please identify) _____
Does your home have stairs? Yes ☐ No ☐ How many?_____

Additional people living with you (check all that apply):

☐ Living Alone
☐ Spouse or Partner Name:_____
☐ Children Name(s):_____
☐ Caregiver Name(s):_____
☐ Other Name(s):_____

Have you experienced any significant changes in the last 12 months? Yes ☐ No ☐
For example: move, family changes, loss, death in the family, etc.

If yes, please provide details: _____

Are you currently experiencing significant stress? Yes ☐ No ☐
For example: legal matters, family discord, finances, etc.

If yes, please provide details:_____

PAST SURGICAL HISTORY

Surgery Name	Year (Approx)	Hospital / Surgeon's Name

PAST MEDICAL HISTORY MAJOR ILLNESSES (check all that apply and add comments that may be helpful)

Alcoholism/ Drug Abuse	Yes ☐ No ☐	
Anemia / Bleeding Problems	Yes ☐ No ☐	
Anxiety	Yes ☐ No ☐	
Cancer	Yes ☐ No ☐	
Dementia / Memory Loss	Yes ☐ No ☐	
Depression	Yes ☐ No ☐	
Diabetes	Yes ☐ No ☐	
Heart Problems	Yes ☐ No ☐	
High Blood Pressure	Yes ☐ No ☐	
High Cholesterol	Yes ☐ No ☐	
Lung Problems	Yes ☐ No ☐	
Thyroid Problems	Yes ☐ No ☐	
Stroke	Yes ☐ No ☐	

Please provide additional details / history if applicable:

For Women:

- Age of Menarche (when your periods started) _____
- Age of Menopause (when your periods stopped) _____
- How many pregnancies? _____
- How many deliveries? _____
- Last Pap Smear _____
- Are you having urinary leakage? Yes ☐ No ☐
- Are you experiencing any discomfort with sexual activity? Yes ☐ No ☐

For Men:

- PSA (Prostate Cancer) Screening Yes ☐ No ☐ Never ☐ Unsure ☐
- Difficulty getting or maintaining erections? Yes ☐ No ☐ Never ☐ Unsure ☐
    - If yes, are you interested in treatments for this? Yes ☐ No ☐
- Are you having urinary leakage? Yes ☐ No ☐

IMMUNIZATIONS Approximate Date

- COVID 19 Vaccine (Pfizer, Moderna, J&J) Yes ☐ No ☐ Unsure ☐ _____
- Influenza Yes ☐ No ☐ Unsure ☐ _____
- Prevnar (PCV13) = Pneumonia #1 Yes ☐ No ☐ Unsure ☐ _____
- Pneumococcal 23 = Pneumonia #2 Yes ☐ No ☐ Unsure ☐ _____
- Shingrix (new Shingles 2 shot series) Yes ☐ No ☐ Unsure ☐ _____
- Tetanus (TDaP or Td) Yes ☐ No ☐ Unsure ☐ _____
- Zostavax (old Shingles shot) Yes ☐ No ☐ Unsure ☐ _____

SCREENINGS (Please indicate dates the following tests were last completed).

- Colon Cancer Screen (Colonoscopy or FIT) _____ Never ☐ Unsure ☐
- Dental Exam _____ Never ☐ Unsure ☐
- DEXA Scan (Bone Density) _____ Never ☐ Unsure ☐
- Eye Exam _____ Never ☐ Unsure ☐
- Hearing Exam _____ Never ☐ Unsure ☐
- Hepatitis C Screening _____ Never ☐ Unsure ☐
- HIV Screen _____ Never ☐ Unsure ☐
- Mammogram _____ Never ☐ Unsure ☐
- Pap Smear _____ Never ☐ Unsure ☐

HABITS

Do you exercise on a regular basis? Yes ☐ No ☐

What kind of exercise:_____How often?_____

How often do you drink alcohol? ☐ Seldom ☐ Socially ☐ Weekends
☐ Daily ☐ Weekly ☐ Never

Drink of choice:_____

Do you **currently** smoke cigarettes? Yes ☐ No ☐

Packs per day (average)_____ When did you start smoking_____

Are you ready to stop smoking? Yes ☐ No ☐

Have you ever regularly smoked cigarettes? Yes ☐ No ☐

Packs per day (average)_____ When did you start smoking_____ stop smoking_____

Do you chew tobacco? Yes ☐ No ☐

Are you exposed to secondhand smoke? Yes ☐ No ☐

Do you use e-cigarettes? Do you vape? Yes ☐ No ☐

Have you used marijuana, THC, or CBD within the past 5 years? Yes ☐ No ☐

Have you used other illicit drugs in the recent or remote past? Yes ☐ No ☐

Please provide details: _____

Would you like to spend more time discussing your current substance use? Yes ☐ No ☐

FAMILY MEDICAL HISTORY

Are your parents still living? Yes ☐ No ☐

If no, how old were they when they died? Mother:_____ Father:_____

Are any of the following medical issues in your family medical history? Please check and circle.

Medical Issue	Family History		Relationship to you		
Alcoholism or drug abuse	Yes ☐	No ☐	parent	sibling	child
Allergies / Asthma	Yes ☐	No ☐	parent	sibling	child
Alzheimer's Disease	Yes ☐	No ☐	parent	sibling	child
Cancer	Yes ☐	No ☐	parent	sibling	child
Depression	Yes ☐	No ☐	parent	sibling	child
Diabetes	Yes ☐	No ☐	parent	sibling	child
Epilepsy / Seizures	Yes ☐	No ☐	parent	sibling	child
Gastrointestinal	Yes ☐	No ☐	parent	sibling	child
Genitourinary	Yes ☐	No ☐	parent	sibling	child
Heart Problems	Yes ☐	No ☐	parent	sibling	child
High Blood Pressure	Yes ☐	No ☐	parent	sibling	child
Thyroid disease	Yes ☐	No ☐	parent	sibling	child
Memory Problems	Yes ☐	No ☐	parent	sibling	child

Musculoskeletal	Yes ☐	No ☐	parent	sibling	child
Neurological problems	Yes ☐	No ☐	parent	sibling	child
OB / Gyn	Yes ☐	No ☐	parent	sibling	child
Parkinson's Disease	Yes ☐	No ☐	parent	sibling	child
Psychiatric Illness	Yes ☐	No ☐	parent	sibling	child
Skin Problem	Yes ☐	No ☐	parent	sibling	child
Stroke	Yes ☐	No ☐	parent	sibling	child

Other _____

_____

ADVANCED CARE PLANNING

Have you filled out the following documents

- Durable Power of Attorney for Health Care Yes ☐ No ☐
- POLST (DNR) Form Yes ☐ No ☐
- Illinois Living Will Form Yes ☐ No ☐

Please provide copies of each of these documents for our records.

Would you like support to learn about or complete these documents? Yes ☐ No ☐

Have you spoken with your family about your advanced care planning? Yes ☐ No ☐

SOCIAL HISTORY

Your birthplace: _____ Where were you mostly raised? _____

Who raised you? _____ What languages were spoken? _____

Are you retired? Yes ☐ No ☐

Highest level of education (degree):_____ Years of Education: _____

Occupation / Work Experience:_____

Have you ever served in the military? Yes ☐ No ☐ Branch _____

Do you have pets at home? Yes ☐ No ☐

Please tell us the names of your pets: _____

Do you spend part of the year outside of Chicago? Yes ☐ No ☐

If yes, please tell us where you go:_____

Please tells us about your hobbies / interests:

_____

_____

_____

NUTRITIONAL ASSESSMENT

Height: _____ Weight: _____

Can you smell as well as before? Yes ☐ No ☐

Does food taste the same as always? Yes ☐ No ☐

How would you describe your appetite: Good ☐ Fair ☐ Poor ☐

Is this a change? Yes ☐ No ☐

Unintentional weight loss or gain of 10 pounds in the past few months? Yes ☐ No ☐

How many times a day do you eat a meal? 1 2 3 >3

Type of Diet: _____

Comments: _____

FALL RISK

Have you fallen within the last 6 months? Yes ☐ No ☐

Do you experience dizziness or unsteadiness when walking? Yes ☐ No ☐

Do you get up 3 or more times at night to use the bathroom? Yes ☐ No ☐

Do you use an assistive device to walk like a cane or walker? Yes ☐ No ☐

Do you wear an emergency button? Yes ☐ No ☐

Comments: _____

DRIVING

Do you have an active driver's license? Yes ☐ No ☐

Do you still drive? Yes ☐ No ☐

Do you wear a seatbelt in the car? Yes ☐ No ☐

Have you had a hospital based driving evaluation? Yes ☐ No ☐

Have you had any accidents or tickets within the past 12 months? Yes ☐ No ☐

Please provide details: _____

_____

Have you gotten lost / confused while driving over the past 12 months? Yes ☐ No ☐

Please provide details: _____

_____

From the following tasks, which ones do you need help with?
Please answer based on your current health.

ACTIVITIES OF DAILY LIVING

	No Assistance Needed	Some Assistance Needed	Complete Assistance Needed	Not Applicable
Bathing				
Dressing				
Grooming				
Oral Care				
Toileting				
Transferring (in/out of bed/chair)				
Walking				
Climbing Stairs				
Eating				
Shopping				
Cooking				
Managing Medications				
Using the phone				
Housework				
Laundry				
Driving				
Managing Finances				

Contact Information: Our office takes great pride in the efforts we make to communicate promptly with patients. Please let us know how best to reach you and your family.

Patient

Preferred phone: (_____)_____□mobile □home

Secondary phone: (_____)_____□mobile □home

Emergency Contact

Name: _____ Phone: (_____)_____□mobile □home

Name: _____ Phone: (_____)_____□mobile □home

Durable Power of Attorney for Healthcare

If you have a completed power of attorney, please list agent and their preferred number.

Name: _____ Phone: (_____)_____□mobile □home

Person completing this form: Patient Spouse Child Other

Name and phone number of person completing this form in case we have questions:

_____

Please return this document to us before your visit.

- Upload the forms through NorthShore Connect (preferred method)
- Fax: 847-503-2228
- Send via mail to our office address. *Please allow 10 days for delivery.*

  Comprehensive Care Center
  2050 Pfingsten Road
  Suite 200
  Glenview, IL 60026

If you are not able to return completed paperwork ahead of your appointment please bring with you to your office visit.

If you have any questions, please contact us at (847) 503-2222.
We look forward to seeing you soon.