NorthShore
University HealthSystem

Medical Group

CONSENT FOR VERBAL RELEASE OF INFORMATION/PERSONAL REPRESENTATIVE

80020-101N (11/2013)

Date: _____

Patient Name: _____ Date of Birth: _____

1. Preferred number:_____ ☐Home ☐Cell ☐Work
2. Can we leave detailed messages, including lab/test results on your voicemail? ☐Yes ☐No

*Answering machines and voice mail must have an identifying message to confirm these are your numbers; for example "You have reached John Doe"

3. Please list any persons with whom we MAY share details about your health care. Indicate below whether this may include Sensitive Health Information** (SHI) such as mental health, developmental disabilities, AIDS/HIV or other STD treatment or diagnosis, Drug/Alcohol abuse diagnosis, treatment and/or referral and Genetic Testing.

Name {Last, First, Middle}	Relationship	Release SHI**? (Yes or No)

I authorize/appoint the following person(s) to accompany my minor child(ren) to appointments at NorthShore University HealthSystem:

Name (Last, First, Middle)	Relationship	Child(ren) Name(s)	Date of Birth

I understand that this consent is valid until it is revoked by me and applies to information about me obtained through any and all NorthShore Medical Group locations and physicians. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent to the physician's office.

Name of person signing: _____

Relationship of person signing: ☐Patient ☐ Parent ☐Guardian

Glenbrook Comprehensive Care Center

NorthShore
University HealthSystem

Medical Group

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:_____

_____

_____

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:_____

_____

Recent physicians you have been seeing:

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: **Name of the place you are living**

☐ House ☐ Senior Community _____

☐ Apartment ☐ Assisted Living Facility_____

☐ Condominium ☐ Other (please identify)_____

Does your home have stairs? Yes ☐ No ☐ How many? _____

Additional people living with you (check all that apply). Please include phone number:

☐ Living Alone

☐ Spouse or Partner Name:_____ phone:_____

☐ Children Name(s):_____ phone:_____

☐ Caregiver Name(s):_____ phone:_____

☐ Other Name(s):_____ phone:_____

☐ Pet Name(s):_____

PAST SURGICAL HISTORY:

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

PAST MEDICAL HISTORY: (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 ☐	
COVID	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 ☐	
Osteoporosis / Fractures	Yes ☐ No ☐	
Thyroid Problems	Yes ☐ No ☐	
Stroke	Yes ☐ No ☐	

Please provide additional details / history if applicable:

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 ☐

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 ☐

IMMUNIZATIONS: (COMPLETE IF YOU DO NOT HAVE A NORTHSHORE PCP) Approximate Dates

- 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 ☐ _____

SCREENING TESTS: Approximate Dates

- 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:

Please tell us what medical issues run in your immediate family:

Medical Issue	Alive / Deceased	Age	Health Issues
Mother	Alive ☐ Deceased ☐	_____	_____
Father	Alive ☐ Deceased ☐	_____	_____
Sister	Alive ☐ Deceased ☐	_____	_____
Brother	Alive ☐ Deceased ☐	_____	_____
Other	Alive ☐ Deceased ☐	_____	_____

Please confirm additional family history you feel is important for us to know: _____

_____

ADVANCED CARE PLANNING:

Have you filled out the following documents

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

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

Would you like 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 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 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 4 or more

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

Caregiver Name (if applicable): _____

Phone: (_____)_____□mobile □home

Hours the caregiver(s) work(s): _____

Emergency Contact:

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

Relationship to patient: _____

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

Relationship to patient: _____

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

Relationship to patient: _____

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)** OR
- Fax: 847-503-2228 OR
- 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.