Staple

2-Hole 1/4 2 3/4 - 3-Hole 1/4 4 1/4

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

OUTPATIENT NEUROLOGY SERVICE
NEW PATIENT QUESTIONNAIRE

Addressograph

PATIENTS: PLEASE COMPLETE THIS QUESTIONNAIRE BEFORE YOU SEE THE PHYSICIAN. The information your answers provide is essential for a thorough evaluation. The following pages include questions regarding your medical history, social history, and family. Please check the boxes or print your response in the given space, as appropriate. If you do not know the answer to a given question, or if it is not applicable in your case, leave it blank. This information will be used to help the physician to learn about you and your medical history in order to make a diagnosis, decide about specific treatment and plan your general care. This information will be kept strictly confidential. Thank you.

Neurology Clinic Physicians

What is your current age? _____ Are you ____ Right-handed or ____ Left-handed or ____ Both?

YOUR NAME AND ADDRESS	**CONTACT INFORMATION**
______________________	Daytime Phone: ______________
______________________	Home Phone: ______________
______________________	Email: ______________
______________________	Fax: ______________

Who referred you for this evaluation? **Physician's Name:** ______________________

Address: ______________________

City: ______________ **State:** ______________ **Zip:** ______________

Phone No: **Fax No:**

What do you see as your main problem or concern?

(Describe when and in what circumstances it started, what part of the body it affects, if it is still worsening, if anything makes it better or worse, if it is worse at a particular time of day, how long does it last if it is intermittent, how it has affected you and what medicines/surgery if any, you have already tried for it)

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MEDICAL HISTORY:

The following is a list of possible medical illnesses. **Please place an "X" beside any that you have or have had in the past.** Please leave the are labeled **"Notes"** blank for the physician's use.

	Notes (please don't write in this column)
___ Stroke	
___ Dementia	
___ Seizures or Epilepsy	
___ Peripheral Neuropathy	
___ Head Injury	
___ Hypertension (high blood pressure)	
___ Heart attack or coronary artery disease	
___ Heart Failure	
___ Irregular heart beat or Arrhythmia	
___ Diabetes	
___ High cholesterol	
___ Asthma or COPD or Emphysema	
___ Cancer	
___ Hepatitis	
___ Thyroid disease	
___ Arthritis – osteoarthritis / Rheumatoid arthritis	
___ Depression	
___ Anxiety	
Other: ________________________________	

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SURGICAL HISTORY:

Procedure	Year	Procedure	Year
Tonsillectomy (tonsils removed)		Adenoidectomy (adenoids removed)	
Appendectomy (appendix removed)		Hysterectomy (uterus removed)	
Cholecystectomy (gallbladder removed)		Coronary Artery Bypass Graft / Stent	
Please list any other surgery that you have had, including the year:			

OBSTETRIC & GYNECOLOGIC HISTORY: (For women only)

Last menstrual period: **Last Gynecologic exam:** **Last PAP smear:**

Pregnancies: **Miscarriages:**

Last Mammogram:

ALLERGIES: Please list all drugs that you are allergic to and **describe** what the allergic reaction was:

REVIEW OF SYSTEMS:
Please circle and provide brief details for the symptoms listed below that apply to you now

CONSTITUTIONAL SYMPTOMS
Fever
Night sweats
Fatigue
Weight gain
Weight loss

RESPIRATORY
Chronic cough
Coughing up blood
Wheezing
Shortness of breath

CARDIOVASCULAR
Chest pain
Irregular heart beat
Shortness of breath
Palpitations
Swelling (feet, ankles, hands)

GASTROINTESTINAL
Loss of appetite
Diarrhea
Constipation
Blood in stools
Rectal bleeding
Nausea
Vomiting
Reflux
Abdominal pain

GENITOURINARY
Urinary urgency
Frequent urination
Blood in urine
Painful urination
Incontinence
Vaginal discharge
Irregular menses
Painful menses
Inability to achieve erection
Inability to perform intercourse

EYES
Blurred vision
Double vision
Eye injury
Discharge from eyes

EAR / NOSE / THROAT
Hearing loss
Ringing in ears
Dizziness
Vertigo
Discharge from ears or nose
Nose bleeds
Bleeding gums
Sinusitis
Lack of taste or smell

INTEGUMENTARY
Skin rash
Itching
Change in skin color
Change in hair or nails
Breast pain
Breast lump
Breast discharge

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REVIEW OF SYSTEMS (continued):

MUSCULOSKELETAL
Join Pain
Joint Stiffness
Joint Swelling
Back Pain
Neck Pain
Cold extremities

ENDOCRINE
Heat or cold intolerance
Excessive thirst or urination
Change in hat or glove size

HEMATOLOGIC/LYMPHATIC
Enlarged nodes or glands
Bleeding tendency
Anemia
Phlebitis

PSYCHIATRIC
Anxiety
Low mood
Fear
Panic attacks
Sadness
Visual hallucinations
Auditory hallucinations

NEUROLOGIC
Headache
Weakness
Stiffness
Numbness
Seizures or convulsions
Tingling
Difficulty chewing
Choking
Difficulty walking
Falls
Tremors
Memory loss
Confusion
Trouble concentrating
Insomnia / trouble sleeping
Snoring

Physician Use Only
☐ **All other systems reviewed and are negative.**

NOTES

SOCIAL HISTORY:

__ Single __ Married __ Divorced __ Widowed __ Separated __ Partnered

Highest Level of Education Completed: __ 6th Grade __ 12th Grade __ G.E.D. __ College __ Post-Graduate

Your employment/occupation ____________________ How long? ____________

Previous Occupations: ______________________________

HABITS: (so we may determine the best way to care for you)

	Present	Past	Age at start	Amount	NOTES
Tobacco (smoking, chewing)	Yes/No	Yes/No		(in packs per day)	
Alcohol	Yes/No	Yes/No			
Other Substances (marijuana, cocaine, heroin, etc)	Yes/No	Yes/No			
Caffeinated Foods (tea, coffee, chocolate)	Yes/No	Yes/No			

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Has the problem you are currently having caused:

Job-Related Problems? __ Yes __ No
School Problems? __ Yes __ No
Legal Problems? __ Yes __ No
Driving Problems? __ Yes __ No

FAMILY HISTORY:

Relative	Current Age(s)	Major Illness(es) (Past or Present?)	If Deceased, Cause of Death?
Mother			
Father			
Sister(s)/Brother(s): please list			

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD. THANK YOU!

NAME OF PERSON COMPLETING THIS FORM: ______________________________

REVIEWED BY:

______________________ M.D. ______________________ M.D. DATE: __________

SIGNATURE PRINTED

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