JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

Patient's ID sticker will go here

Welcome!

Johns Hopkins Hospital Division of Gastroenterology
Patient Questionnaire

Please fill out and bring to the clinic at the time of your appointment. ***DO NOT MAIL.***

Patient Name: _____ Date: _____

Birth Date: _____ Johns Hopkins MRN: _____
(This is the same number as the kiosk barcode# on the attached HandHolder™ appt letter)

E-mail Address (if preferred): _____ Cell Phone Number: _____

Who referred you to the Johns Hopkins Gastroenterology Clinic? Referring Physician: _____

Address: _____

Telephone #: _____ Fax: _____

Other Physicians to receive copies of your evaluation:

Physician's Name: _____

Address: _____

Telephone #: _____ Fax: _____

Physician's Name: _____

Address: _____

Telephone #: _____ Fax: _____

What is the primary medical problem for which you seek evaluation information or treatment?

_____

_____

PAST HISTORY:

Indicate if you have had any of the following:

☐ Anemia	☐ Heart murmur	☐ Hepatitis	☐ Seizures	☐ Stroke	☐ Asthma	☐ HIV
☐ Diabetes	☐ Heart attack	☐ Lung disease	☐ Kidney disease	☐ Cancer	☐ Sleep Apnea	
☐ Tuberculosis	☐ Mental illness	☐ Depression	☐ Thyroid disease	☐ High cholesterol	☐ COPD/Lung disease	

What other illness have you had? (Name and approximate date)

_____

_____

_____

Current weight: _____ Lowest weight: _____ Highest weight: _____

Immunizations: ☐ Influenza ☐ Tetanus/diphtheria ☐ Pneumonia ☐ Hepatitis B ☐ Hepatitis A

Surgeries: Have you had any surgery? ☐ No ☐ Yes If yes, list type of operation and approximate date

_____

_____

GASTRO 101A NL (rev 12/09)

Tear here and take this bottom part home with you so you can remember important things.

THINGS TO REMEMBER TO ASK MY DOCTOR

1. What is my main problem? _____
2. What do I need to do? _____
3. Why is it important for me to do this? _____
4. When will I start to feel better? _____
5. Other notes _____

In the past 3 years have you had a:

☐ Yes ☐ No Stool tested for blood
☐ Yes ☐ No Flex-sigmoidoscopy
☐ Yes ☐ No Upper endoscopy
☐ Yes ☐ No Colonoscopy
☐ Yes ☐ No Blood cholesterol level
☐ Yes ☐ No Prostatic specific antigen test (PSA)
☐ Yes ☐ No Chest X-ray
☐ Yes ☐ No Electrocardiogram (ECG)
☐ Yes ☐ No Mammogram
☐ Yes ☐ No Pap Smear and Pelvic exam
☐ Yes ☐ No CT scan or MRI of abdomen
☐ Yes ☐ No Liver biopsy
☐ Yes ☐ No Stress test

PERSONAL HISTORY:

Education – How many years of school have you completed? _____

Current employment status: ☐ retired ☐ unemployed ☐ homemaker ☐ employed: occupation _____

Disability – Are you disabled? ☐ No ☐ Yes If yes, cause: _____

Have you used any of the following substances?

Substance	Current Use	Previous Use	Type/Amount	If stopped when
Caffeine (coffee, tea, soda)				
Tobacco				
Alcohol (beer, wine, liquor)				
Recreational/street drugs				

Marital Status: ☐ Single ☐ Separated ☐ Divorced ☐ Widowed (list cause of death) _____
☐ Married (list any health problems) _____
Spouse's current employment status: ☐ retired ☐ unemployed ☐ homemaker ☐ employed
Spouse's current occupation: _____

FAMILY HISTORY Some names may be used for either men or women, please indicate sex for each brother, sister, son or daughter. You may omit names.

	IF LIVING Sex	Age	Health	IF DECEASED Age at Death	Cause
Father					
Mother					
Siblings					
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				
Spouse/Partner	☐ M ☐ F				
Children					
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				
_____	☐ M ☐ F				

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help.
We want you to live a healthier life.

Do you know of any blood relative who has or had: (Check all tha apply and give relationship to you)

☐ Breast cancer_____ ☐ Colon cancer _____

☐ Ovarian cancer _____ ☐ Uterine cancer _____

☐ Esophageal cancer_____ ☐ Pancreatic cancer_____

☐ Gastric cancer _____ ☐ Other cancer_____

☐ Rheumatologic/Autoimmune disease _____ ☐ High cholesterol/triglycerides _____

☐ Epilepsy _____ ☐ Migraine _____

☐ Liver disease _____ ☐ Kidney disease _____

☐ Heart disease _____ ☐ Diabetes _____

☐ Mental illness _____ ☐ Alcohol or Drug abuse _____

☐ Lung disease _____ ☐ Genetic disorder _____

☐ Ulcer (duodenal or gastric) _____ ☐ Goiter_____

☐ Crohn's disease_____ ☐ Irritable bowel syndrome _____

☐ Stroke/TIA _____ ☐ High blood pressure _____

☐ Arthritis_____

REVIEW OF SYSTEMS: Do you have, or have you had, any of the following problems?

General: ☐ Poor appetite ☐ Weight loss ☐ Weight gain ☐ Easy fatigability ☐ Fever or abnormal sweating

Skin: ☐ Itching ☐ Rash ☐ Yellowing

Hematological: ☐ Easy bruising ☐ Blood clots ☐ Enlarged lymph nodes ☐ Transfusion

Head: ☐ Eye trouble ☐ Hearing disorder ☐ Sore tongue or mouth ☐ Yellow eyes ☐ Snoring

Neck: ☐ Goiter ☐ Lumps or masses

Chest: ☐ Chest pain ☐ Shortness of breath ☐ Palpitations ☐ Asthma ☐ Chronic cough ☐ High blood pressure

GI: ☐ Heart burn ☐ Difficulty swallowing ☐ Indigestion ☐ Milk intolerance ☐ Persistent nausea or vomiting
☐ Vomiting blood ☐ Passing blood ☐ Abdominal pain ☐ Diarrhea ☐ Constipation ☐ Abdominal swelling

GU: ☐ Difficulty with urination ☐ Blood in urine ☐ Dark urine ☐ Kidney stones

Females Only: Any difficulty with menstrual periods? ☐ No ☐ Yes Last menstrual period: _____/_____/_____

Contraceptive use: _____ Estrogen replacement? ☐ No ☐ Yes

Extremities: ☐ Arthritis ☐ Swollen legs ☐ Cold sensitivity ☐ Muscle pain

Neurological: ☐ Recurrent headaches ☐ Loss of consciousness ☐ Seizures ☐ Loss of memory ☐ Confusion ☐ Tremor
☐ Weakness or numbness of face or extremities ☐ Psychological depression ☐ Anxiety

Current Medications – List all medications you take. Include how much and how often.

Name	**Dose/Frequency**	**Name**	**Dose/Frequency**

Allergies – Have you had any allergy to any medications? ☐ No ☐ Yes, If yes, list name and reaction below:

Name	**Type of Reaction**	**Name**	**Type of Reaction**

Reviewing Physician:_____ Date: _____

Your healthcare is very important to us.

Thank you for choosing

Johns Hopkins Hospital Division of Gastroenterology.

JOHNS HOPKINS
MEDICINE

THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

Patient Name

JH Medical Record #:

Outpatient Medication List

Directions: Update and give a copy of this list to the patient with each outpatient visit.
Do not use abbreviations.

❑ Patient taking no medication regularly and none in the past 72 hours.

MEDICATIONS (include over-the-counter and herbal medications)	**DOSE** (e.g., strength, # of pills or drops)	**ROUTE** (e.g., by mouth, inhaled, on skin)	**FREQUENCY** (how often)
Example: Vitamin C	*250 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

New Medications – Please enter all new medications below.

MEDICATION	**DOSE**	**ROUTE**	**FREQUENCY**	**COMMENT**
1.				
2.				
3.				
4.				

Please use additional sheet for more medications.

_____ _____ / / _____ _____

Reviewed by (Name and credentials of health care provider) Date Time

If you have questions about any of your medications, please contact the person who prescribed them.