

**Johns Hopkins Pituitary Tumor Center
New Patient Questionnaire**

Dear Patient:

Welcome to the Pituitary Tumor Center at Johns Hopkins University. We ask that you take some time to complete this questionnaire to the best of your knowledge. This questionnaire will allow the doctor to get to know more about you, your medical condition, your family and your habits. We ask that you fill this form out prior to your visit and bring it with you on the date of your appointment so that there will be no delay when you arrive. This questionnaire is confidential and will be kept as part of your medical record. If you have any questions about issues of confidentiality, please feel free to contact our legal office for clarification at 410-955-7949.

Date of Visit: _____

Patient's age: _____ Date of Birth: _____

Patient's name: _____

Patient's Height: _____ Weight: _____

Are you: Left handed or Right Handed (circle one)

Full Name: _____

Address: _____

Phone: _____

Who referred you to our office?

Name: _____

Address: _____

Phone: _____ Fax: _____

Specialty: _____

Please list all other physicians who should receive a copy of our report:

1) Name: _____

2) Name: _____

Address: _____

Address: _____

3) Name: _____

4) Name: _____

Address: _____

Address: _____

History of Present Illness:

Briefly describe the reason for your visit. _____

1. What types of symptoms are you experiencing? _____

2. How severe is the problem? _____
3. How long have you had the problem? _____
4. How often do the symptoms occur? _____ How long do the symptoms last? _____
5. Does anything help make the problem go away? Yes / No If so, what? _____
6. What makes the problem worse? _____
7. Have you ever had surgery, radiation, chemotherapy, or any other treatment for this problem? _____

Review of systems:

Please circle and provide brief detail for the medical conditions below which apply to you now or in the past.

Constitutional:

Weight loss or gain
Change in appetite
Excessive sleepiness
Unable to sleep
Fatigue
Fever

Eyes:

Cataracts
Blurred vision
Double vision
Glaucoma

Respiratory:

Asthma
Emphysema
Chronic cough
Tuberculosis
Bronchitis
Pneumonia
Shortness of breath

Ears, Nose, Mouth, Throat:

Balance problems
Ringing in ears
Dizziness
Nose bleeds/discharge
Hearing loss
Trouble breathing through nose
Sinus disease
Mouth sores
Trouble swallowing
Sore throat

Musculo-skeletal

Low back pain
Enlargement of hands/feet
Joint pain
Joint swelling

Skin

Skin Rashes
Psoriasis

Psychiatric

Depression
Anxiety
Trouble concentrating

Gastrointestinal:

Rectal bleeding
Diarrhea
Ulcer
Hepatitis
Abdominal pain
Vomiting
Constipation
Gastritis
Hiatal hernia
Gallbladder

Genitourinary

Kidney stones
Blood in urine
Urinary urgency
Urinary incontinence
Sexual Dysfunction
Impotence
Venereal disease
Vaginal Bleeding
Frequent urination
Breast milk production

Cardiovascular:

Chest pain
Chest pressure
Angina
Fainting
Leg swelling
High blood pressure
Low blood pressure
Heart murmur
Heart failure

Hemo-lymphatic

Blood disorder
Enlarged lymph nodes
Sickle Cell disease
HIV/AIDS

Endocrine

Thyroid disease
Diabetes
Low blood sugar

Neurologic

- Seizures
- Loss of consciousness
- Headache
- Memory loss
- Trouble walking
- Trouble with balance
- Numbness
- Falls
- Weakness

Other:

Please list all other current medical problems as well as major illnesses you have had in the past with approximate dates?

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

Previous work up.

Have you had any recent hormonal blood test? If yes, what are the approximate dates? Do you have them with you?

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Have you had a recent pituitary MRI? If yes, what are the approximate dates? Do you have the films?

- | | |
|----------|----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |

Medications:

Please list all medications you are currently taking including over the counter drugs with dosage and times when they are taken:

- | | |
|----------|-----------|
| 1. _____ | 2. _____ |
| 3. _____ | 4. _____ |
| 5. _____ | 6. _____ |
| 7. _____ | 8. _____ |
| 9. _____ | 10. _____ |

Do you take aspirin or any medicines that contain aspirin? Yes No

Allergies:

- a. **Food allergies:** _____
- b. **Drug allergies:** _____
- c. **Latex allergy:** _____
- d. **Tape allergy:** _____

Past Medical History:

Please list all operations you have had in the past with approximate dates.

- 1) Surgery: _____ 2) Surgery: _____
Date: _____ Date: _____
- 3) Surgery: _____ 4) Surgery: _____
Date: _____ Date: _____

Have you ever had a problem with anesthesia? If so, when & what _____
 Have you ever had a blood transfusion? Yes No If yes, When? _____ Why? _____

(Women Only)

Last menstrual cycle: _____ Are you post-menopausal? Yes No If so, what date? _____
 Date of last gynecological exam with pap result _____
 Date of last mammogram and result _____
 Have you ever been pregnant? Yes No If so, how many times? _____
 How many deliveries have you had? _____

Family History:

Please list current age and medical problems (if any) of the following family members. If any are deceased, please list cause and approximate age of death in parentheses.

Grandparents: _____ Aunts: _____

 _____ Uncles: _____

Father: _____

Mother: _____

Brothers: (List ages and medical problem) _____

Sisters: (List ages and medical problem) _____

Children: (List ages and medical problem) _____

Social History:

JHU Pituitary Center

Please circle your highest level of education:

Grade school High school/Vocational College Masters/Doctorate

Where do you work? (If retired, list most recent place of employment and date of retirement)

What is your position there? _____

Are you: Single Married Divorced Separated (Circle one)

Current living arrangement: (circle one) Live alone; Live with roommate; Live with spouse; Live with parents/sibling

Do you smoke? Yes No If you smoked and quit, date you quit _____

If you smoke, how many packs per day? _____ How long have you been smoking? _____

Do you drink caffeinated beverages (coffee, tea, soda) Yes No If yes, how much a day? _____

Do you drink alcohol? Yes No

If you drink alcohol, approximately how many drinks per week? _____

Have you ever had a problem with alcohol? _____

Have you ever had a problem with drugs? _____

Any other information that you feel you would like to tell us, please write below.

I give permission for the following people to discuss my care with the staff of the Pituitary Tumor Center.

Name	Relationship
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____

Date: _____