



**JOHNS HOPKINS NEUROSURGERY
NEW PATIENT HISTORY QUESTIONNAIRE**

Welcome to the Department of Neurosurgery at Johns Hopkins. 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 out this form prior to your visit, and bring it with you on the date of your appointment. 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 Name: _____ Age: _____

Are you right-handed or left-handed? (circle one) Height: _____ Weight: _____

Address: _____

Phone Numbers: (H) _____ (W) _____ (Cell) _____

WHO REFERRED YOU TO OUR OFFICE?

Physician Name: _____

Address: _____

Phone: _____ Fax: _____

Specialty: _____

PLEASE LIST ALL OTHER PHYSICIANS WHO SHOULD RECEIVE A COPY OF OUR REPORT:

Name: _____

Address: _____

Phone: _____ Fax : _____

Name: _____

Address: _____

Phone: _____ Fax: _____

Name: _____

Address: _____

Phone: _____ Fax: _____

HISTORY OF PRESENT ILLNESS:

1. What is the reason for your visit today? _____
2. How long have you had the problem? _____
3. How severe is the problem? _____
4. What type of symptoms are you experiencing? _____
5. How often do the symptoms occur? _____
6. How long do the symptoms last? _____
7. Does anything make the problem better? _____
8. Does anything make the problem worse? _____
9. Have you ever had treatment or surgery for this problem? _____
10. Please rate your pain on a scale from 0 (no pain) to 10 (worst imaginable). _____

REVIEW OF SYSTEMS:

Please circle and provide brief detail for the medical conditions below that apply to you now.

GENERAL

Weight loss or gain
Change in appetite
Altered taste or smell
Excessive sleepiness
Unable to sleep
Fatigue

EYE

Blurred vision
Double vision
Glaucoma
Cataracts

CARDIOVASCULAR

Chest pain
Chest pressure
Angina
Fainting
Leg swelling
High blood pressure
Low blood pressure
Heart Murmur
Heart Failure
Shortness of breath

EARS, NOSE, MOUTH, THROAT

Balance problems
Trouble breathing
Sinus disease
Mouth sores
Trouble swallowing
Sore Throat
Ringing in ears
Dizziness
Hearing loss

RESPIRATORY

Emphysema
COPD
Tuberculosis
Chronic cough
Bronchitis
Pneumonia

GASTROINTESTINAL

Ulcer
Hepatitis
Vomiting
Constipation
Diarrhea
Bowel incontinence
Gastritis
Hiatal hernia
Rectal bleeding

NEUROLOGICAL

Headache
Seizure
Loss of consciousness
Memory loss
Weakness
Trouble walking
Trouble with balance
Numbness
Tingling
Concussion
Falls
Vertigo

PAST MEDICAL HISTORY:

Please list all current medical problems as well as major illness you have had in the past with approximate dates.

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

GENITOURINARY

Kidney Stones
Urinary urgency
Urinary incontinence
Sexual dysfunction
Impotence
Vaginal bleeding
Painful urination
Frequent urination
Blood in urine

MUSCULOSKELETAL

Low back pain
Neck pain
Joint pain
Joint swelling

HEMATOLOGICAL

Blood disorder
Leukemia
Sickle Cell Disease
Enlarged lymph nodes
HIV

PSYCHIATRIC

Depression
Anxiety
Trouble concentrating

INTEGUMENTARY

Skin rash

ENDOCRINE

Diabetes
Thyroid Disease

PAST SURGICAL HISTORY:

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

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever had a problem with anesthesia? _____ If yes, please explain. _____

Have you ever had a blood transfusion? _____ If yes, why? _____

MEDICATIONS:

Please list all medications you are currently taking, including over the counter medications, with dosage.

1. _____
2. _____
3. _____
4. _____
5. _____

Do you take aspirin or any medicines that contain aspirin, such as Ibuprofen or Motrin? _____

If yes, please specify. _____

ALLERGIES:

Please list any known drug and food allergies:

1. _____
2. _____

FAMILY HISTORY:

Please list all medical problems and current age of the following family members. If they are deceased, please list the cause and approximate age of death.

Grandparents: _____ **Aunts:** _____

_____ **Uncles:** _____

Father: _____ **Mother:** _____

Brothers: _____

Sisters: _____

Children: _____

Grandchildren: _____

SOCIAL HISTORY:

What is your highest level of education? _____

What is your occupation? _____

Are you disabled? _____

Was the injury due to a work-related accident? _____

Was the injury due to a non-work-related injury? _____

Was the illness/injury caused by an automobile accident? _____

Was another party responsible for this accident? _____

Is there any litigation involved? _____ **If yes, please explain.** _____

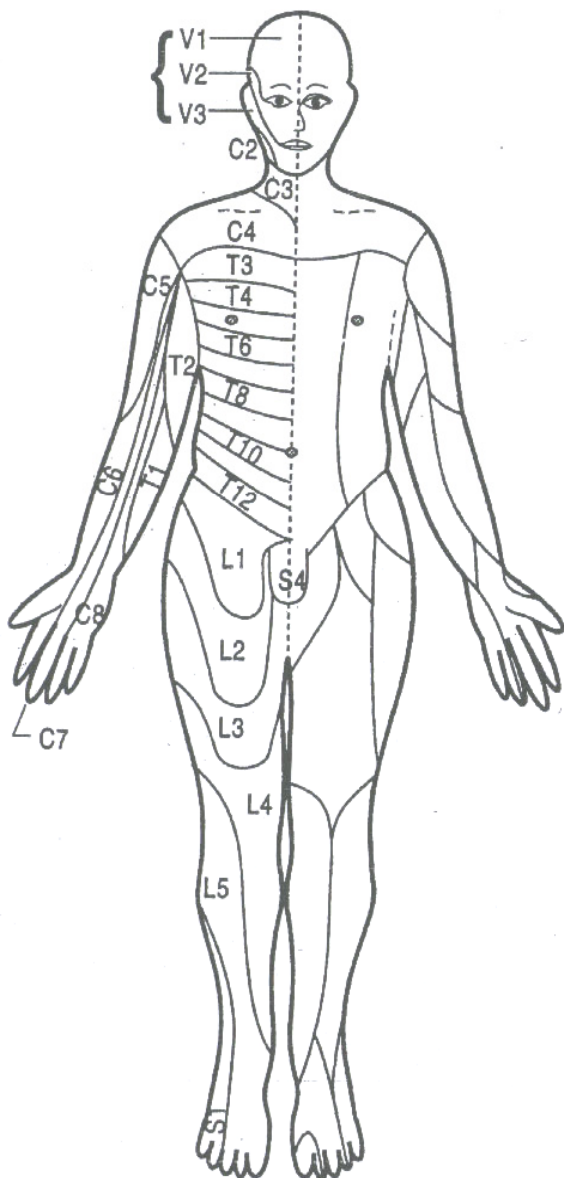
Do you smoke? _____ **If yes, how much and for how long?** _____

If you quit, when did you quit? _____

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

Please mark on the diagram below to show areas of pain.

ANTERIOR



POSTERIOR

