

PATIENT QUESTIONNAIRE

Please Print

MEDICATIONS List all your current medications and the dose you take

Current Medications	Dosage/Frequency	Current Medications	Dosage/Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you take Aspirin or Ibuprofen? Yes No Do you take Warfarin (Coumadin)? Yes No
 Do you take any herbal medicines? Yes No Have you taken steroids in the last year? Yes No

ALLERGIES List medications/foods you are allergic to and what happens when you take them

Allergen	Reaction	Allergen	Reaction
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY Check all illnesses that run in your family

<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Heart disease	<input type="checkbox"/> Others
<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Psychiatric illness	<input type="checkbox"/> Cancer	_____
<input type="checkbox"/> Sickle cell anemia	<input type="checkbox"/> Bleeding problems	<input type="checkbox"/> Diabetes	_____
<input type="checkbox"/> Poor circulation	<input type="checkbox"/> Anesthesia reaction	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Thyroid disease/cancer	<input type="checkbox"/> Voice problems	<input type="checkbox"/> Epilepsy	_____

SOCIAL HISTORY

Occupation _____ How many children do you have? _____

Marital status Never married Married Separated Divorced Living with Partner Widowed

Check tobacco products you use or have used in the past Cigarettes Cigars Pipe Chew Never used

How much, and for how long have you used tobacco? _____ per day for _____ years Never used

How much alcohol do you drink each day? _____ How much caffeine do you drink per day? _____

List any street drugs you currently or have ever used _____

REVIEW OF SYSTEMS Check all symptoms you have had either now or in the past

CONSTITUTIONAL

Weight loss _____ pounds in the past _____ weeks Fever, chills Weakness or fatigue

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.

PATIENT QUESTIONNAIRE

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REVIEW OF SYSTEMS

continued

EYES:

- Double vision
- Loss of vision
- Eye pain
- Eye drainage
- Dry eyes

EARS, NOSE, THROAT:

- Hearing loss
- Ringing in ears
- Dizziness
- Ear pain
- Ear drainage
- Toothaches

- Nose bleeds
- Nose drainage
- Nasal congestion
- Facial pain
- Headaches
- Sore mouth/throat

- Swallowing pain
- Voice change
- Snoring
- Hoarseness
- Poor sleep
- Neck pain or swelling

CARDIOVASCULAR/PULMONARY

- Chest pain
- Poor circulation
- Shortness of breath

- Heart attack
- Leg pain during walking
- Asthma or wheezing

- Irregular heartbeat
- Frequent cough

- Bronchitis
- Coughing up blood

GASTROINTESTINAL

- Stomach ulcers
- Heartburn

- Nausea/vomiting
- Trouble swallowing

- Diarrhea
- Abdominal pain

- Frequent antacid use
- Blood in stool

GENITOURINARY

- Blood in urine

- Pain during urination

- Difficulty making urine

MUSCULOSKELETAL

- Neck or back pain

- Muscle aches

- Arthritis

NEUROLOGICAL

- Stroke
- Facial paralysis
- Numbness in face, arms or legs

- Mini-stroke or TIA
- Paralysis of arm or leg

- Head trauma
- Confusion
- Temporary loss of vision or speech control
- Seizure
- Memory loss

SKIN

- Skin cancers
- Allergy to tape, iodine or latex

PSYCHIATRIC

- Depression
- Hallucinations
- Schizophrenia
- Anxiety or panic attacks

- Other psychiatric disorders (Please list) _____

INFECTIOUS DISEASE

- Hepatitis
- Syphilis
- HIV/AIDS
- TB

- Mononucleosis
- Shingles
- Any sexually transmitted disease _____

I have personally reviewed this history and review of systems:

Attending Physician's Signature

Date

(To be completed by Johns Hopkins Physician)

**Your healthcare is very important to us.
Thank you for choosing Johns Hopkins Medicine.**