



Johns Hopkins Otolaryngology-Head and Neck Surgery Medical Second Opinion Program

Patient Intake Form

First Name: _____ M.I.: __ Last Name: _____

PERSONAL INFORMATION (REQUIRED)

Date of Birth: ____ / ____ / _____ Social Security Number: ____ - ____ - _____

Mother's Maiden Name: _____ Father's Full Name: _____

CONTACT INFORMATION (REQUIRED)

Home Phone: (____) ____ - _____ Cell Phone: (____) ____ - _____

Work Phone: (____) ____ - _____ Other Phone: (____) ____ - _____

Email _____

Is it okay to contact you at work: Yes No

Street Address: _____ Apt: _____

City: _____ State: _____ Zip: _____

MEDICAL QUESTIONS (REQUIRED)

What is your current diagnosis / disease / disorder in question?

What do you hope to gain by engaging the services of a medical second opinion?

What explicit questions do you want answered within the medical second opinion?
