Name ______________________________ Date of Birth ______________

JOHNS HOPKINS
MEDICINE
For
Neurology

PATIENT HISTORY QUESTIONNAIRE

PATIENT INFORMATION

PATIENT		***JHH#***			
ADDRESS		***DOB#***		***AGE***	
		SSN#			
HOME PH		***DAY PH***			

Who is your ***REFERRING PHYSICIAN***? (The doctor who referred you to Johns Hopkins Neurology.)
Please be sure to include street address and zip code so we can mail reports.

NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	

Who is your ***PRIMARY CARE PHYSICIAN***? (The doctor who coordinates your care.)
Please be sure to include street address and zip code so we can mail reports.

NAME		***SPECIALTY***	
ADDRESS		***PHONE***	

If you were not referred to *JOHNS HOPKINS NEUROLOGY* by a doctor, who suggested you come here, or how did you find out about our department?

We will send copies of your reports to the *Referring Physician* and *Primary Care Physician* listed above. Is there anyone else who should receive copies?

NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	

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REVISED 6/2003

Name ____ Date of Birth ______________

CHIEF COMPLAINT Please briefly describe the purpose of this visit.	Physician Notes

HISTORY OF PRESENT ILLNESS	NOTES
What signs or symptoms are you experiencing?	
What part(s) of your body does this problem affect?	
How long have you had this problem?	
How often do the symptoms occur?	
Do symptoms occur at a particular time of day? If so, when?	
How long do the symptoms last?	
How severe is the problem?	
Does anything help make the problem go away? If so, what?	
Does anything seem to make the problem worse? If so, what?	
Have you had prior treatment or surgery for this problem? If so: What: By whom: Result:	

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REVIEW OF SYSTEMS - GENERAL Please check any conditions you have experienced.							
CONSTITUTIONAL		**EARS, NOSE, MOUTH, THROAT**		**CARDIOVASCULAR**		**HEMI-LYMPHATIC**	
Y/N	Altered taste/ smell	Y/N	Balance problem	Y/N	Angina	Y/N	Blood disorder
Y/N	Change in appetite	Y/N	Dizziness	Y/N	Chest pain	Y/N	Diabetes
Y/N	Weight loss or gain	Y/N	Ringing in ears	Y/N	Chest pressure	Y/N	Endocrine disorder
Y/N	Unable to sleep	Y/N	Hearing loss	Y/N	Fainting	Y/N	Sickle Cell Disease
Y/N	Excessive sleepiness	Y/N	Trouble breathing through nose	Y/N	Heart Failure	Y/N	Thyroid Disease
Y/N	Fatigue	Y/N	Nose bleeds / discharge	Y/N	Heart Murmur	Y/N	Enlarged lymph nodes
Y/N	Fever	Y/N	Sinus disease	Y/N	High blood pressure	Y/N	HIV
		Y/N	Mouth sores	Y/N	Low blood pressure	Y/N	AIDS
		Y/N	Sore throat	Y/N	Shortness of breath		
		Y/N	Trouble swallowing	Y/N	Leg swelling		
MUSCULOSKELETAL		**EYES**		**GASTROINTESTINAL**		**RESPIRATORY**	
Y/N	Low back pain	Y/N	Blurred vision	Y/N	Abdominal pain	Y/N	Bronchitis
Y/N	Neck pain	Y/N	Double vision	Y/N	Constipation	Y/N	Emphysema
Y/N	Joint pain	Y/N	Glaucoma	Y/N	Diarrhea	Y/N	Pneumonia
Y/N	Joint swelling	Y/N	Cataracts	Y/N	Gastritis	Y/N	Tuberculosis
				Y/N	Hepatitis	Y/N	Chronic cough
INTEGUMENTARY		**PSYCHIATRIC**		Y/N	Hiatal Hernia		
Y/N	Breast disease	Y/N	Anxiety	Y/N	Rectal bleeding		
Y/N	Skin rash	Y/N	Depression	Y/N	Ulcer		
		Y/N	Trouble concentrating	Y/N	Vomiting		
REVIEW OF SYSTEMS – NEUROLOGIC							
Y/N	Confusion	Y/N	Clumsiness	Y/N	Choking	Y/N	Blurred vision
Y/N	Difficulty Concentrating	Y/N	Facial numbness / tingling	Y/N	Difficulty chewing	Y/N	Decreased hearing
Y/N	Dizziness	Y/N	Numbness - arms (L/ R/	Y/N	Difficulty tasting	Y/N	Diplopia
Y/N	Hallucinations	Y/N	Numbness - legs (L/ R/	Y/N	Drooling	Y/N	Dysphagia
Y/N	Headache	Y/N	Poor balance	Y/N	Hoarseness	Y/N	Syncope
Y/N	Lethargy	Y/N	Poor coordination	Y/N	Incontinence- bowel	Y/N	Tinnitus
Y/N	Memory problems	Y/N	Speech difficulty	Y/N	Incontinence- bladder	Y/N	Trouble with smell
Y/N	Personality change	Y/N	Stiffness	Y/N	Nausea	Y/N	Vertigo
Y/N	Spells	Y/N	Trouble walking	Y/N	Pain		
		Y/N	Weakness - arms (L/ R/	Y/N	Vomiting		
		Y/N	Weakness - legs (L/ R/				

ALL OTHERS NEGATIVE _______

Name ____ Date of Birth _______________

CURRENT MEDICATIONS Please list all medications you take, including over the counter drugs.			
DRUG	DOSE/ FREQUENCY	PRESCRIBED BY	TAKEN SINCE

Do you take aspirin or any medicines that contain aspirin? __Yes __No

DRUG ALLERGIES AND REACTIONS

Are you allergic to any medications? If so, please list the medication and your reaction to it.

MEDICATION	REACTION	MEDICATION	REACTION

PAST MEDICAL HISTORY

SURGERIES

Please list all operations you have had, with approximate dates

PROCEDURE	DATE	SURGEON	RESULT

Have you ever had a problem with anesthesia? __Yes __No
If so, what substance and what complication?

Have you ever had a blood transfusion? __Yes __No
If so, when? Why?

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Please list all other current medical problems and hospitalizations you had in the past with approximate dates.
(Use separate page if necessary.)

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children	NOTES
Arthritis							
Bleeding disorder							
Cancer							
CNS Tumors							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
Hypertension							
Kidney Disease							
Neuromuscular Disease							
Stroke							
Thyroid Disease							

GYN/ OB MEDICAL HISTORY

LAST MENSTRUAL PERIOD: ARE YOU POST-MENOPAUSAL? __YES __NO DATE OF MENOPAUSE:

DATE OF LAST GYNECOLOGICAL EXAM WITH PAP SMEAR: RESULT:

DATE OF LAST MAMMOGRAM: RESULT:

HAVE YOU EVER BEEN PREGNANT? __YES __NO IF SO, HOW MANY TIMES? _________
HOW MANY DELIVERIES HAVE YOU HAD? _________ HAVE YOU EVER HAD A MISCARRIAGE? __YES __NO

PATIENT SOCIAL HISTORY

HOW OLD ARE YOU? HEIGHT: WEIGHT:

ARE YOU: __ LEFT-HANDED __ RIGHT-HANDED __ BOTH

ARE YOU: __ SINGLE __ MARRIED __ WIDOWED __ SEPARATED __ DIVORCED

IF YOU ARE MARRIED, WHAT IS YOUR SPOUSE'S OCCUPATION?

Name ____ Date of Birth ____________

DO YOU LIVE: ___ ALONE	__ WITH SPOUSE	__ WITH ROOMMATE	__ WITH PARENTS/SIBLINGS
WHAT IS YOUR HIGHEST LEVEL OF EDUCATION? __ GRADE SCHOOL __ HIGH SCHOOL __VOCATIONAL SCHOOL __ COLLEGE __ GRADUATE SCHOOL			
WHERE DO YOU WORK? (IF RETIRED, LIST MOST RECENT PLACE OF EMPLOYMENT AND DATE OF RETIREMENT)			
WHAT IS/ WAS YOUR POSITION THERE?			
WHAT ARE YOUR HOBBIES?			
DO YOU SMOKE? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _______ HAVE YOU EVER SMOKED? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _______ WHEN DID YOU STOP?			
DO YOU DRINK ALCOHOL? __YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _______ HAVE YOU EVER DRUNK ALCOHOL? __YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _______ WHEN DID YOU STOP?			

PLEASE TELL US ANYTHING ELSE ABOUT YOURSELF OR YOUR CONDITION THAT YOU THINK WE SHOULD KNOW.