JOHNS HOPKINS
MEDICINE

Patient ID will go here.

Welcome!

☐ Johns Hopkins Hospital ☐ Johns Hopkins Bayview ☐ Johns Hopkins Community Physicians

☐ Other_____

Neurosurgery 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 and your medical condition. **Please complete this form before your visit, and bring it with you the day of your appointment. Also bring your insurance card, driver's license or identification card, reports of previous neurological and neurosurgical testing consultations (MRI, CT, X-RAY, images or CDs), and reports of significant medical problems.**

PATIENT INFORMATION

Full Name_____

Date of Birth _____ Age_____ Email _____

Address_____

City_____ State _____ ZIP _____

Phone Numbers: Home_____ Work _____ Cell _____

Emergency Contact: Name _____ Phone _____

REFERRING PHYSICIAN INFORMATION

Physician Name_____ Specialty _____

Address _____ City _____ State_____ ZIP_____

Phone _____ Fax _____

Is there anyone else who should receive a copy of the clinic report? (i.e., Primary care physician)

Physician Name_____ Specialty _____

Address _____ City _____ State_____ ZIP_____

Phone _____ Fax _____

PRESENT ILLNESS

1. What is the reason for your visit today? _____

   _____

2. What symptoms are you currently experiencing?_____
3. How long have you had these symptoms? _____ How often do they occur?_____
4. How severe are the symptoms on a scale of 0 (no pain) to 10 (worst imaginable)? _____
5. Does anything make the problem better? ☐ Yes ☐ No Explain _____
6. Does anything make the problem worse? ☐ Yes ☐ No Explain _____
7. Have you had treatment for the problem? ☐ Yes ☐ No Explain _____

   _____

   _____

   _____

8. Have you had any spinal surgeries in the past? ☐ Yes ☐ No (Date and Location)_____

   _____

REVIEW OF SYSTEMS

Please check the medical condition(s) below which apply to you either now or in the past.

Constitution
- ☐ Activity change
- ☐ Appetite change
- ☐ Chills
- ☐ Diaphoresis
- ☐ Fatigue
- ☐ Fever
- ☐ Unexpected weight change

Head-Ears-Nose-Throat
- ☐ Facial swelling
- ☐ Neck pain
- ☐ Neck stiffness
- ☐ Ear discharge
- ☐ Hearing loss
- ☐ Ear pain
- ☐ Tinnitus–Ringing in ears
- ☐ Nosebleeds
- ☐ Congestion
- ☐ Rhinorrhea–Runny nose
- ☐ Postnasal drip
- ☐ Sneezing
- ☐ Dental problem
- ☐ Drooling
- ☐ Mouth sores
- ☐ Sore throat
- ☐ Trouble swallowing
- ☐ Voice change

Eyes
- ☐ Eye discharge
- ☐ Eye itching
- ☐ Eye pain
- ☐ Eye redness
- ☐ Photophobia
- ☐ Visual disturbance

Respiratory
- ☐ Apnea
- ☐ Chest tightness
- ☐ Choking
- ☐ Cough
- ☐ Shortness of breath
- ☐ Stridor–Abnormal breathing sounds
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain
- ☐ Leg swelling
- ☐ Palpitations

Gastrointestinal
- ☐ Abdominal distention
- ☐ Abdominal pain
- ☐ Anal bleeding
- ☐ Blood in stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Nausea
- ☐ Rectal pain
- ☐ Vomiting

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Polydipsia–Excessive thirst
- ☐ Polyphagia–Excessive hunger
- ☐ Polyuria–Excessive urine

Genitourinary
- ☐ Difficulty urinating
- ☐ Dysuria–Painful urination
- ☐ Enuresis–Unable to control urination
- ☐ Flank pain
- ☐ Frequent urination
- ☐ Genital sore
- ☐ Hematuria–Blood in urine
- ☐ Penile discharge
- ☐ Penile pain
- ☐ Penile swelling
- ☐ Scrotal swelling
- ☐ Testicular pain
- ☐ Urgency–Urinary urgency
- ☐ Urine decreased

Muscular
- ☐ Arthralgias–Joint pain
- ☐ Back pain
- ☐ Gait problem
- ☐ Joint swelling
- ☐ Myalgias–Muscle pain

Skin
- ☐ Color change
- ☐ Pallor–Paleness
- ☐ Rash
- ☐ Wound

Allergies and Immunology
- ☐ Environmental allergies
- ☐ Food allergies
- ☐ Immunocompromised

Neurological
- ☐ Dizziness
- ☐ Facial asymmetry
- ☐ Headaches
- ☐ Light-headedness
- ☐ Numbness
- ☐ Seizures
- ☐ Speech difficulty
- ☐ Syncope–Fainting
- ☐ Tingling
- ☐ Tremors
- ☐ Weakness

Hematologic
- ☐ Adenopathy–Enlarged lymph nodes
- ☐ Bruises/bleeds easily

Psychiatric
- ☐ Agitation
- ☐ Behavior Problem
- ☐ Confusion
- ☐ Decreased concentration
- ☐ Dysphoric mood–Depressed
- ☐ Hallucinations
- ☐ Hyperactive
- ☐ Nervous/anxious
- ☐ Self-injury
- ☐ Sleep disturbance
- ☐ Suicidal ideas

PAST MEDICAL HISTORY

Please mark all current medical problems and major illness you have had with approximate dates.

	DATE			DATE	
ADD/ADHD		☐ Yes ☐ No	Hypogonadism		☐ Yes ☐ No
Allergic rhinitis		☐ Yes ☐ No	Hypothyroidism		☐ Yes ☐ No
Alzheimer's disease		☐ Yes ☐ No	Intracranial aneurysm		☐ Yes ☐ No
Anemia		☐ Yes ☐ No	Irritable bowel syndrome		☐ Yes ☐ No
Arrhythmia		☐ Yes ☐ No	Kidney stones		☐ Yes ☐ No
Arthritis		☐ Yes ☐ No	Lower extremity edema		☐ Yes ☐ No
Asthma		☐ Yes ☐ No	Lyme disease		☐ Yes ☐ No
Back pain		☐ Yes ☐ No	Migraine		☐ Yes ☐ No
Cancer		☐ Yes ☐ No	Mitral/aortic valve disease		☐ Yes ☐ No
Carotid stenosis		☐ Yes ☐ No	Morbid obesity		☐ Yes ☐ No
Carpal tunnel		☐ Yes ☐ No	Multiple sclerosis		☐ Yes ☐ No
Celiac disease		☐ Yes ☐ No	Myocardial infarction		☐ Yes ☐ No
Congestive heart failure		☐ Yes ☐ No	Myopathy		☐ Yes ☐ No
Chiari malformation		☐ Yes ☐ No	NEC		☐ Yes ☐ No
Chronic kidney disease		☐ Yes ☐ No	Neck pain		☐ Yes ☐ No
Chronic pain		☐ Yes ☐ No	Neuropathy		☐ Yes ☐ No
Chronic obstructive pulmonary disease		☐ Yes ☐ No	Normal pressure hydrocephalus		☐ Yes ☐ No
Coronary artery disease		☐ Yes ☐ No	Obstructive hydrocephalus		☐ Yes ☐ No
Dementia		☐ Yes ☐ No	Osteoporosis		☐ Yes ☐ No
Dermatological disorder		☐ Yes ☐ No	Parkinson's		☐ Yes ☐ No
Diabetes		☐ Yes ☐ No	Peptic ulcer disease		☐ Yes ☐ No
Diverticulosis		☐ Yes ☐ No	Pneumonia		☐ Yes ☐ No
Deep vein thrombosis/Pulm. embolism		☐ Yes ☐ No	Pseudomeningocele		☐ Yes ☐ No
Epilepsy		☐ Yes ☐ No	Pseudotumor cerebri		☐ Yes ☐ No
Facial Pain		☐ Yes ☐ No	Scoliosis		☐ Yes ☐ No
Gastritis		☐ Yes ☐ No	Seizures		☐ Yes ☐ No
Gastroesophageal reflux disease		☐ Yes ☐ No	Self-catheterization (urinary)		☐ Yes ☐ No
Glaucoma		☐ Yes ☐ No	Shingles		☐ Yes ☐ No
Gout		☐ Yes ☐ No	Shunt infection		☐ Yes ☐ No
Hearing loss		☐ Yes ☐ No	Sinus thrombosis		☐ Yes ☐ No
Hepatitis		☐ Yes ☐ No	Sleep apnea		☐ Yes ☐ No
Herniated invertebral disk		☐ Yes ☐ No	Spinal stenosis		☐ Yes ☐ No
Hydrocephalus		☐ Yes ☐ No	Stroke		☐ Yes ☐ No
Hypercholesterolemia		☐ Yes ☐ No	Von Hippel-Lindau disease		☐ Yes ☐ No
Hyperglycemia		☐ Yes ☐ No	Other:		
Hypertension		☐ Yes ☐ No	Other:		
Hyperthyroidism		☐ Yes ☐ No	Other:		

SURGICAL HISTORY

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

	DATE			DATE	
Appendectomy		☐ Yes ☐ No	Pituitary resection		☐ Yes ☐ No
Bariatric surgery		☐ Yes ☐ No	Prostatectomy		☐ Yes ☐ No
Brain tumor resection		☐ Yes ☐ No	Pseudomeningocele repair		☐ Yes ☐ No
Breast biopsy		☐ Yes ☐ No	Radiosurgery		☐ Yes ☐ No
Breast implant		☐ Yes ☐ No	Shunt		☐ Yes ☐ No
Coronary artery bypass graft		☐ Yes ☐ No	Shunt revision		☐ Yes ☐ No
Cardiac valve surgery		☐ Yes ☐ No	Skin surgery		☐ Yes ☐ No
Carotid endarterectomy		☐ Yes ☐ No	Spinal (column) tumor resection		☐ Yes ☐ No
Carpal tunnel release		☐ Yes ☐ No	Spinal fusion		☐ Yes ☐ No
Cholecystectomy–Gallbladder removal		☐ Yes ☐ No	Spine surgery		☐ Yes ☐ No
Clipping of intracranial aneurysm		☐ Yes ☐ No	Splenectomy		☐ Yes ☐ No
Colon surgery		☐ Yes ☐ No	Stent		☐ Yes ☐ No
Coronary stent		☐ Yes ☐ No	Strabismus surgery		☐ Yes ☐ No
Craniotomy		☐ Yes ☐ No	Subdural hematoma drainage		☐ Yes ☐ No
Discectomy		☐ Yes ☐ No	Tendon lengthening/transfer		☐ Yes ☐ No
Ear tubes		☐ Yes ☐ No	Thyroid surgery		☐ Yes ☐ No
G-Tube/ PEG placement		☐ Yes ☐ No	Tonsillectomy		☐ Yes ☐ No
Hernia repair		☐ Yes ☐ No	Vascular surgery		☐ Yes ☐ No
Hysterectomy		☐ Yes ☐ No	Other:		☐ Yes ☐ No
Joint surgery		☐ Yes ☐ No	Other:		☐ Yes ☐ No
Laminectomy		☐ Yes ☐ No	Other:		☐ Yes ☐ No
Mastectomy		☐ Yes ☐ No	Other:		☐ Yes ☐ No

Have you ever had a blood transfusion or received blood products? ☐ Yes ☐ No Date _____

Have you had any problems with anesthesia? ☐ Yes ☐ No

If yes, please explain _____

Do you take aspirin, any medicines that contain aspirin, Ibuprofen, Advil, or Motrin? ☐ Yes ☐ No

Do you take any blood thinners such as Plavix, Coumadin, or Lovenox? ☐ Yes ☐ No

If yes, please list last date taken _____

DRUG ALLERGIES

DRUG	REACTION	DRUG	REACTION

FOOD ALLERGIES

FOOD	REACTION	FOOD	REACTION

FAMILY HISTORY

If you have any relatives, including children, with serious medical conditions (such as asthma, high blood pressure, heart attacks, kidney problems, diabetes, seizures, strokes, cancers, etc.) please list below.

RELATION	AGE	CONDITION

SOCIAL HISTORY

Alcohol Use	Yes	No	Drinks/Week	Tobacco Use	Yes	No	Years	Packs/Day	Quit Date
Glass(es) of Wine	☐	☐	_____	Cigarettes	☐	☐	_____	_____	_____
Can(s) of Beer	☐	☐	_____	Smokeless Tobacco	☐	☐	_____	_____	_____
Shot(s) of Liquor	☐	☐	_____	Ready to quit?	☐	☐	_____	_____	_____
Drink(s) containing 0.5 oz of alcohol	☐	☐	_____	Counseling given?	☐	☐	_____	_____	_____

Drug Use ☐ Yes ☐ No

Type of Drug	Amount Used/Week

Gender: ☐ Male ☐ Female Height:_____ feet _____ inches Weight:_____lbs.

What is your highest level of education?_____ Are you disabled? ☐ Yes ☐ No

Are you currently working? ☐ Yes ☐ No If yes, what is your occupation? _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated

Living arrangement: ☐ Alone ☐ Roommate(s) ☐ Spouse ☐ Children ☐ Parent(s)/Sibling(s)

Do you have children? ☐ Yes ☐ No If yes, list age(s) and health conditions.

AGE OF CHILD	CONDITION(S)	AGE OF CHILD	CONDITION(S)

COMPLETED BY: PRINTED NAME_____

SIGNATURE_____ DATE _____TIME _____

REVIEWED BY: _____M.D. DATE _____TIME _____

_____M.D. DATE _____TIME _____

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD.

THANK YOU!

JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL
600 NORTH WOLFE STREET
BALTIMORE, MD 21287

Patient Name

JH Medical Record #:

Outpatient Medication List

Directions: Update and give a copy of this list to the patient with each outpatient visit.
Do not use abbreviations.

❑ Patient taking no medication regularly and none in the past 72 hours.

MEDICATIONS (include over-the-counter and herbal medications)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, inhaled, on skin)	FREQUENCY (how often)
Example: Vitamin C	*250 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

New Medications – Please enter all new medications below.

MEDICATION	DOSE	ROUTE	FREQUENCY	COMMENT
1.				
2.				
3.				
4.				

Please use additional sheet for more medications.

_____ _____/____/_____ _____

Reviewed by (Name and credentials of health care provider) Date Time

If you have questions about any of your medications, please contact the person who prescribed them.