JOHNS HOPKINS MEDICINE
JOHNS HOPKINS COMMUNITY PHYSICIANS

New Patient Questionnaire

Patient Name: _____Birthdate: _____

Pharmacy Name/Location: _____

Lab: HOPKINS LAB CORP QUEST

Radiology: Advanced Radiology American Radiology Anne Arundel Diagnostics

Other:_____

Medical/Surgical History

1. **Do you have any of the following medical problems? Check all that apply.**
   - ☐ Asthma/Lung Disease ☐ Diabetes ☐ Heart Disease ☐ Liver Diseases/Hepatitis
   - ☐ Hypertension ☐ Seizure Disorder ☐ Blood Clots
   - ☐ Depression ☐ Ulcers ☐ Stroke
   - ☐ Other: _____
2. **Do you have allergies to medications or foods?**
   - ☐ No ☐ Yes Please list them: _____
3. **Do you take any medications or supplements?**
   - ☐ No ☐ Yes Please list them: _____
4. **Have you ever had any surgical procedures done?**
   - ☐ No ☐ Yes Please list them: _____
   - _____
   - _____

Obstetrical History

1. **Have you ever had a miscarriage?** ☐ No ☐ Yes
   - **If so, how many?** _____
2. **Have you ever had an abortion?** ☐ No ☐ Yes
   - **If so, how many?** _____
3. **Have you ever had an ectopic (tubal) pregnancy?** ☐ No ☐ Yes
   - **If so, how many?** _____
4. **Do you have any biological children?** ☐ No ☐ Yes *If so, please complete the table below.*

Child's First Name	Sex	DOB	Weight at Birth	Vaginal? (V) Cesarean? (C)	Hospital	Outcome of Pregnancy (i.e. living, deceased, miscarriage, abortion, adopted)
1.						
2.						
3.						
4.						
5.						

MRN: _____

Gynecologic History

1. **When was your last pap smear?** _____
2. **Have you ever had a pap smear that was abnormal?** ☐ No ☐ Yes
3. **When was your last mammogram?** _____
4. **Have you ever been treated for sexually transmitted diseases/infections?** ☐ No ☐ Yes

   If so, which one(s)?

   ☐ Herpes ☐ Syphilis ☐ Trichomonas ☐ Hepatitis B

   ☐ HIV ☐ Gonorrhea ☐ Chlamydia ☐ HPV/Genital Warts
5. **Are you currently sexually active?** ☐ No ☐ Yes
   - **If no, have you ever been sexually active?** ☐ No ☐ Yes
   - **If yes, is it a mutually monogamous relationship?** ☐ No ☐ Yes
   - **Do you have sex with men, women, or both?** ☐ Men ☐ Women ☐ Both
   - **What type of contraception do you use?**

     ☐ Condoms ☐ Birth Control Pills ☐ Contraceptive Patch ☐ Contraceptive Ring

     ☐ Norplant ☐ IUD ☐ Diaphragm ☐ Partner had vasectomy

     ☐ Tubal Ligation ☐ None
6. **When was your last menstrual period?** _____
7. **Are you experiencing problems with your menstrual period?** ☐ No ☐ Yes
8. **How old were you when you had your first menstrual period?** _____
   - **How long does your cycle last? (e.g. 3-7 days)** _____
   - **How long is the period between your cycles? (e.g. 28 days)** _____
9. **Are you experiencing any menopausal symptoms?** ☐ No ☐ Yes
10. **How old were you when you became sexually active?** _____
11. **How many sexual partners have you had in your lifetime?**

    ☐ 0 ☐ 1 ☐ 2-4 ☐ 5-10 ☐ 11-15 ☐ 16-20 ☐ 20+

Social History

1. **Are you married?** ☐ No ☐ Yes
2. **Do you smoke cigarettes?** ☐ No ☐ Yes
3. **Do you drink alcohol?** ☐ No ☐ Yes
4. **Do you use illegal drugs?** ☐ No ☐ Yes
5. **Do you work outside the home?** ☐ No ☐ Yes

   If yes, what type of work do you do? _____

Family History

1. **Do any of the following conditions occur in your family? Who are the family members?**

   ☐ Breast Cancer ☐ Uterine Cancer ☐ Ovarian Cancer ☐ Colon Cancer

   ☐ Uterine Fibroids ☐ Heart Disease ☐ Hypertension ☐ Diabetes

   ☐ Stroke ☐ Other (list below)

   _____

I certify that the information above is accurate and complete:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Provider Signature: _____ Date: _____