Patient Name:
Patient DOB:

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JOHNS HOPKINS
MEDICINE

NEW PATIENT QUESTIONNAIRE
Pediatric Epilepsy Center

We look forward to meeting you in your upcoming appointment in the Pediatric Epilepsy Center at the Johns Hopkins Outpatient Center. The information in this questionnaire will help us to make the most of your visit. Please fill it out before your clinic visit and mail it to our office visit with the medical records. We will review the information together at the visit and invite you to ask questions and add detail about any item that you choose. This completed form will be kept as part of your child's medical record.

Patient Name: _____ Patient DOB: _____
Patient Address: _____
_____
Patient Home Phone: _____
Primary Caretaker Cell Phone: _____
Primary Caretaker E-Mail Address_____
Name and Relationship of Person
Completing Questionnaire: _____

Please list here the names, addresses and telephone numbers of those doctors who referred you to us, as well as any other physician(s) or health care providers involved in this patient's care to whom you request we send out report.

1. Referring Physician:

_____
_____
_____
_____
_____
_____

2. Physician/Health Care Provider (other than referring physician)

_____
_____
_____
_____
_____
_____

Signed: _____

Date: _____

PLEASE TRY TO MAIL IN ADVANCE ALL REPORTS OF PREVIOUS CONSULTATIONS AND EEGs/MRIs ON CD AS WELL AS THE REPORT. IF THIS ISN'T POSSIBLE THEN THEY MAY BE HANDCARRIED TO VISIT.

Patient Name:
Patient DOB:

Questions you wish to have answered (i.e., your goals for the visit). Because our time is limited, please list below the most important questions you would like answered at this visit.

Patient's age:

Is your child left- or right-handed, ambidextrous (both), or neither?

Is there a history of any of the following before the onset of seizures: brain infections (including meningitis, encephalitis), head injuries, or problems with the patient's birth history (or the mother's pregnancy)? If so, please explain.

History of Present Illness: Please describe the problem(s) in detail by answering the following questions:
What signs or symptoms is you child experiencing?

How long have these symptoms been present?

What part(s) of the body and what functions are being affected?

How often do these symptoms occur?

Do these symptoms occur at a particular time of day? *If yes, please explain when.*

How severe is the problem? What impact does this have on the child's daily life?

How long do these symptoms last?

Does anything make the symptoms better? *If yes, please explain.*

Does anything make the symptoms worse? *If yes, please explain.*

Has there been prior treatment or surgery for this problem?

If yes, please explain the following:

What type of treatment?

By whom?

What was the result of treatment?

Please describe all other current medical problems and past medical illnesses.

Please list all past surgical procedures with estimated dates:

Please list any current medications including doses and times given:

Medication	**Dose**	**Time(s) given**

Patient Name:
Patient DOB:

BIRTH AND DEVELOPMENT HISTORY
What was your child's birth weight? (_____ Lbs, _____ ounces) How long was the pregnancy?
Were there any problems during the pregnancy? Yes No
Was your child born by Caesarian section ("C-section")? If so, why? Yes No
Did your child have any problems as a newborn? (first month of life)? Yes No
How long did your child stay in the hospital after birth?
Any concerns about abnormal or slow development?
If yes, please tell me more about when you were first concerned about this, and the nature of this problem.
Has your child ever lost developmental skills? Yes No
Does your child receive any specialized treatment services or special education program (for example an IEP, physical therapy or special classroom placement)? Yes No
If yes, please describe:
What grade is your child in? Are any subjects more challenging than others?
Does your child receive special classroom or classroom modifications? Yes No If "yes," please list
SOCIAL HISTORY
Does your child live: with parents / with others (please specify)
Are you (the child's caregiver): Single Married Widowed Separated Divorced
Name (or just age and gender) of siblings. Who lives in the same home?
What is your (child's caregiver) occupation? What is the child's other parent's occupation? Occupations of others who live with the child?
Are there any special social stresses at home or school that would be important for me to know? Yes No
FAMILY HISTORY
Does anyone in the family have a history of seizures, epilepsy, or convulsions? Yes No If so, please list.
Does anyone in the family have a history of developmental delays, neurological illness, or psychiatric issues? If so, please list.
Does anyone in the family see a neurologist, psychiatrist, geneticist, or specialist for brain or behavior issues? Yes No

Patient Name:

Patient DOB:

Does the patient have any allergies to medications: ☐ ***YES*** ☐ ***NO***

If yes, please list medication and the nature of the reaction.

REVIEW OF SYSTEMS – GENERAL Please check any important other problems your child is experiencing now or recently							
CONSTITUTIONAL		**EAR, NOSE, THROAT**		**CARDIOVASCULAR**		**HEME -LYMPHATIC**	
☐	Altered taste/ smell	☐	Ringing in ears / Hearing loss	☐	Fainting	☐	Blood disorder
☐	Change in appetite	☐	Stuffy nose	☐	Chest pain/pressure	☐	Sickle Cell Disease
☐	Weight loss or gain	☐	Nose bleeds / discharge	☐	Heart Murmur	☐	Enlarged lymph nodes
☐	Poor growth	☐	Sinus disease	☐	Heart Failure	☐	HIV exposure
☐	Unable to sleep	☐	Mouth sores	☐	High blood pressure	☐	AIDS
☐	Excessive sleepiness	☐	Sore throat	☐	Low blood pressure	**GASTROINTESTINAL**	
☐	Fatigue	☐	Trouble swallowing	☐	Leg swelling	☐	Abdominal pain
☐	Fever If so, recurrent?	**URINARY**		**EYES**		☐	Constipation
ENDOCRINE		☐	Increased frequency	☐	Double Vision/Blind Spots	☐	Diarrhea
☐	Thyroid Disease/growth problems	☐	Bedwetting	☐	Blurred vision	☐	Vomiting
☐	Diabetes	☐	Kidney/bladder deformity	☐	Cataracts	☐	Hepatitis
☐		☐	Renal Stones	☐	Glaucoma	☐	Rectal bleeding
RESPIRATORY		☐	Trouble toilet training	☐	Eye deformity	☐	Ulcer
☐	Asthma	☐		**MUSCULOSKELETAL**		☐	Reflux
☐	Chronic cough	**SKIN/INTEGUMENT**		☐	Joint swelling	**PSYCHIATRIC**	
☐	Bronchitis	☐	Rash	☐	Joint deformity	☐	Anxiety
☐	Pneumonia	☐	Birthmarks	☐	Joint/limb pain	☐	Depression
☐	Tuberculosis	☐	Abnormal nails	☐	Neck/back pain	☐	Trouble concentrating or Behavior/ Emotional problems
☐	Snoring	☐	Abnormal hair	☐	Broken bones	☐	Attention problems
REVIEW OF SYSTEMS – NEUROLOGIC							
☐	Confusion	☐	Clumsiness	☐	Difficulty swallowing	☐	Decreased hearing
☐	Difficulty Concentrating	☐	Facial numbness / tingling	☐	Difficulty chewing	☐	Tics
☐	Dizziness	☐	Numbness - arms (L/ R/ B)	☐	Difficulty tasting	☐	Fainting spells
☐	Hallucinations	☐	Numbness - legs (L/ R/ B)	☐	Drooling	☐	Ringing in the ears
☐	Headache	☐	Poor balance	☐	Hoarseness	☐	Trouble with smell
☐	Lethargy	☐	Poor coordination/ abnormal movements	☐	Incontinence- bowel	☐	Head size
☐	Memory problems	☐	Stiffness	☐	Incontinence- bladder	☐	
☐	Personality change	☐	Trouble walking	☐	Nausea	_____ All other 12 systems negative.	
☐	Spells	☐	Weakness - arms (L/ R/ B)	☐	Pain	Reviewed by: _____	
☐	Speech difficulty	☐	Weakness- legs (L/R/ B)	☐		Date: _____	
☐	Sleep problems (including falling asleep, frequent awakenings, night terrors, sleep walking)						

For second opinion consultation:

When you scheduled this appointment, you indicated that you were seeking a second opinion, which we are happy to provide. We will be able to give you a more thorough assessment if we are able to review all of the pertinent records. Since the scheduled appointment is for one hour, it will be helpful to have these records well organized. Please mail this new patient questionnaire, child's neurological clinic notes, EEGs and MRIs on CD and the reports and any other testing that has been done for your child's epilepsy to
The John M. Freeman Pediatric Epilepsy Center 600 N. Wolfe St.
Meyer 2-147
Baltimore, MD 21287

Please keep in mind this is only where records are sent. Your visit will be in the Johns Hopkins Outpatient Center, 601 N. Caroline Street, Baltimore, MD 21287.

In providing this consultation it is important for you to understand that we are seeing your child in order to discuss the diagnosis, prognosis and treatment. We cannot provide continuing care to all of the children we see for a second opinion, especially when they are already under the established care of an appropriate specialist. We look forward to meeting you and your child at the upcoming visit.