Print Form

JOHNS HOPKINS
MEDICINE

Hereditary Hemorrhagic Telangiectasia (HHT)

New Patient Questionnaire

DATE: _____

PATIENT INFORMATION

PATIENT NAME: _____ **Date of Birth:** _____

ADDRESS: _____

HOME PHONE: _____ **WORK PHONE:** _____ **CELL PHONE:** _____

Emergency CONTACT/Name_____**Phone**_____**Cell Phone**_____

MOTHER'S MAIDEN NAME: _____ **SOC. SEC. NUMBER:** _____

FATHER'S NAME:_____ **Email Address:**

Height: _____ **Weight:**_____

INSURANCE INFORMATION/PRIMARY

INSURANCE CARRIER: _____ **MEMBER ID#** _____ **GROUP #** _____

ADDRESS: _____ **PHONE #:** _____

SUBSCRIBER NAME: _____

INSURANCE INFORMATION/SECONDARY

INSURANCE CARRIER: _____ **MEMBER ID#** _____ **GROUP #** _____

ADDRESS: _____ **PHONE #:** _____

SUBSCRIBER NAME: _____

Who is your **REFERRING PHYSICIAN?**
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 _____ **FAX** _____

List other specialists/MDs that care for you.
Please be sure to include street address and zip code so we can mail reports.

NAME _____ **SPECIALTY** _____

ADDRESS _____

PHONE _____ **FAX** _____

NAME _____ **SPECIALTY** _____

ADDRESS _____

PHONE _____ **FAX** _____

NAME _____ **SPECIALTY** _____

ADDRESS _____

PHONE _____ **FAX** _____

HHT FOUNDATION REFERRAL: **YES** ○ **No** ○

Please explain why you are seeking medical evaluation at Johns Hopkins Hospital HHT Center:

Medical History

I have been diagnosed with the following medical conditions:

Medical Diagnosis/Condition	Date of Diagnosis	Doctor who diagnosed medical condition	Symptoms

Surgical History

I have had the following surgeries:

PROCEDURE	DATE	SURGEON	RESULT

Describe any problems you have had in the past with anesthesia or sedation:

Medications

Please list all medications you are taking, including prescription, over the counter, vitamins, supplements and alternative medications:

DRUG	DOSE	How many times per day you take medication

MEDICATION	REACTION	TREATMENT
OTHER ALLERGIES		
LATEX		
IODINE		
SEAFOOD		
CONTRAST / DYE		
FOOD		

REVIEW OF SYSTEMS - NEUROLOGIC					
Confusion	☐	Poor balance	☐	Blurred vision	☐
Difficulty Concentrating	☐	Poor coordination	☐	Decreased hearing	☐
Dizziness	☐	Speech difficulty	☐	Ringing in the ears	☐
Hallucinations	☐	Trouble walking	☐	Double vision	☐
Memory problems	☐	Weakness- arms left/right/ or both	☐	Fainting spells	☐
Personality change	☐	Weakness- legs left/right/ or both	☐	Trouble with smell	☐
Seizures	☐	Choking	☐	TIA/mini stroke	☐
Clumsiness	☐	Difficulty chewing	☐	Stroke	☐
Facial numbness / tingling	☐	Difficulty tasting	☐	Headaches	☐
Numbness– arms left/right/ or both	☐	Drooling	☐	Migraines	☐
Numbness– legs left/right/ or both	☐	Hoarseness	☐	**AVMs of brain Arteriovenous Malformations**	☐

Please provide details of any checked responses above:

EARS, NOSE, MOUTH, THROAT		CARDIOVASCULAR		GASTROINTESTINAL		HEMI-LYMPHATIC	
Balance problem	☐	Angina	☐	Abdominal pain	☐	Blood disorder	☐
Dizziness	☐	Chest pain	☐	Constipation	☐	Diabetes	☐
Ringing in ears	☐	Chest pressure	☐	Diarrhea	☐	Endocrine disorder	☐
Hearing loss	☐	Fainting	☐	Gastritis	☐	Diabetes Type I or Type II	☐
Trouble breathing through nose	☐	Heart Failure	☐	Hepatitis	☐	Sickle Cell Disease	☐
Nose bleeds / discharge	☐	Heart Murmur	☐	Hiatal hernia	☐	Thyroid Disease	☐
Sinus disease	☐	High blood pressure	☐	Rectal bleeding	☐	Enlarged lymph nodes	☐
Mouth sores	☐	Low blood pressure	☐	Ulcer	☐	HIV exposure	☐
Sore throat	☐	Shortness of breath	☐	Vomiting	☐	AIDS	☐
Trouble swallowing	☐	Leg swelling	☐	Polyps	☐	Von Willabrands	☐
AVMs/telangiectasia of nose Arteriovenous Malformations	☐	Hole in Heart	☐	Loss of Bowel Control	☐	Hepatitis	☐
		Pacmaker	☐	Blood in Stool	☐	Infectious Disease	☐
		Defibrillator	☐	**AVMs of GI tract Arteriovenous Malformations**	☐		
				AVMs of liver Arteriovenous Malformations	☐		

Please provide details of any checked responses above:

CONSTITUTIONAL		RESPIRATORY		MUSCULOSKELETAL		EYES	
Altered taste/smell	☐	Bronchitis	☐	Low back pain	☐	Blurred vision	☐
Change in appetite	☐	Emphysema	☐	Neck pain	☐	Double vision	☐
Weight loss or gain	☐	Pneumonia	☐	Joint pain	☐	Glaucoma	☐
Unable to sleep	☐	Tuberculosis	☐	Joint swelling	☐	Cataracts	☐
Excessive sleepiness	☐	Chronic cough	☐	**AVMs of spine Arteriovenous Malformations**	☐		
Fatigue	☐	**AVMs of lungs Arteriovenous Malformations**	☐				
Fever	☐						

Please provide details of any checked responses above:

INTEGUMENTARY		PSYCHIATRIC		URINARY	
Breast disease	☐	Anxiety	☐	Increased frequency	☐
Skin rash	☐	Depression	☐	Loss of bladder control	☐
Port wine stain	☐	Trouble concentrating	☐	Blood in urine	☐
AVMs of Skin/ Telangiectasia	☐	Alcoholism	☐	Kidney stones	☐
		Drug Abuse	☐	Sexual dysfunction	☐
		Tobacco/cigarettes	☐		
		Tobacco/chew	☐		

Please provide details of any checked responses above:

SCHOOLING / EDUCATION
HIGH SCHOOL/Degree:
College/Degree:
Occupation/Job:
Exposure to Environmental Hazards **Industry** **Chemicals** **Radiation** **Other**

Please provide details of any environmental exposures:

Please Check which best describes your activity level:

I	No symptoms and no limitation in ordinary physical activity	☐
II	Mild symptoms and slight limitation during ordinary activity	☐
III	Marked limitation in activity due to symptoms, even during less -than -ordinary activity	☐
IV	Severe limitations. Experiences symptoms even at rest	☐

MRI/CT Screening questions:

1. **Do you have any metal in your body?**_____
2. **Are you allergic to contrast/dye used during imaging (MRI/CT)?**_____
3. **Do you have diabetes, kidney or liver problems?**_____

Family History

Mother	**Age**	**Health Problems**	**Cause of Death**
Father			
Your Aunt s (mother's sisters)			
Your Uncles(mother's brothers)			
Your Aunts(father's sisters)			
Your Uncles(father's brothers)			
Grandparents(your mother's parents)			
Grandparents(your father's parents)			
Your Brothers			
Your Sisters			
Your children			

Your children			
Your children			
Your children			
Spouse/Significant other			

Please provide any additional information that we may need to know about you:

Diagnostic Test/Records	**Have you had this test?**
Chest X-Ray	**DATE**
Brain-MRI with Contrast	**DATE**
Lungs-3 D CTA Cat Scan	**DATE**
Liver-3 D CTA Cat Scan	**DATE**
Blood Test- CBC w Differential	**DATE**
Blood Test- Comprehensive Metabolic Panel	**DATE**
Blood Test- PT/PTT	**DATE**
Agitated Saline/Bubble Echo	**DATE**
GI-Endoscopy	**DATE**
GI-Capsule Endoscopy	**DATE**
GI-Augmented Small Bowel Enteroscopy	**DATE**
GI-Colonoscopy	**DATE**
Genetic Testing	**DATE**
Other	**DATE**
Other	**DATE**
Complete New Patient Questionnaire	**DATE**
Insurance Card-Copy Front and Back	**DATE**
Request medical Records **1. Problem list** **2. Recent Physical** **3. Recent lab tests** **4. Hospital Adm/Surg** **5. Medications/Allergies** ***less than 20 pages please**	**DATE**

_____	