



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

SURGICAL HISTORY

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

	DATE			DATE	
Appendectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Pituitary resection		<input type="checkbox"/> Yes <input type="checkbox"/> No
Bariatric surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No	Prostatectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No
Brain tumor resection		<input type="checkbox"/> Yes <input type="checkbox"/> No	Pseudomeningocele repair		<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast biopsy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiosurgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Breast implant		<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunt		<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary artery bypass graft		<input type="checkbox"/> Yes <input type="checkbox"/> No	Shunt revision		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac valve surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No	Skin surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Carotid endarterectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal (column) tumor resection		<input type="checkbox"/> Yes <input type="checkbox"/> No
Carpal tunnel release		<input type="checkbox"/> Yes <input type="checkbox"/> No	Spinal fusion		<input type="checkbox"/> Yes <input type="checkbox"/> No
Cholecystectomy–Gallbladder removal		<input type="checkbox"/> Yes <input type="checkbox"/> No	Spine surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Clipping of intracranial aneurysm		<input type="checkbox"/> Yes <input type="checkbox"/> No	Splenectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No
Colon surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No	Stent		<input type="checkbox"/> Yes <input type="checkbox"/> No
Coronary stent		<input type="checkbox"/> Yes <input type="checkbox"/> No	Strabismus surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Craniotomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Subdural hematoma drainage		<input type="checkbox"/> Yes <input type="checkbox"/> No
Discectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Tendon lengthening/transfer		<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear tubes		<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
G-Tube/ PEG placement		<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hernia repair		<input type="checkbox"/> Yes <input type="checkbox"/> No	Vascular surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No
Hysterectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Joint surgery		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Laminectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> No
Mastectomy		<input type="checkbox"/> Yes <input type="checkbox"/> No	Other:		<input type="checkbox"/> Yes <input type="checkbox"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	_____	Cigarettes	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Can(s) of Beer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Smokeless Tobacco	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Shot(s) of Liquor	<input type="checkbox"/>	<input type="checkbox"/>	_____	Ready to quit?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Drink(s) containing 0.5 oz of alcohol	<input type="checkbox"/>	<input type="checkbox"/>	_____	Counseling given?	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

Drug Use	<input type="checkbox"/> Yes	<input type="checkbox"/> 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 _____

JH NEUSURG SP NPQ E (05/14)

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD.

THANK YOU!



JOHNS HOPKINS
M E D I C I N E

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)
<i>Example: Vitamin C</i>	<i>250 mg</i>	<i>By mouth</i>	<i>Once a day</i>
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.