JOHNS HOPKINS

MEDICINE

Psychiatry and Behavioral Sciences

PATIENT CONSULTATION QUESTIONNAIRE

Patient Questionnaire - Schizophrenia 2nd Opinion Consultation

These questions are designed to assist our team with the screening process and to assure that the consultation at Johns Hopkins addresses your concerns. Take your time and answer the following questions. Be as detailed as possible. Please feel free to ask for help from family or friends. If there are any questions that do not apply to you and or questions that you do not know the answer to, please type an "NA" **(not applicable or not available)** in the blank. Feel free to add other information that may increase the quality of the consultation, on the last page of this questionnaire.

This Questionnaire should be completed with the Patient Demographic form and sent to:

Attn:	**JHH Psychiatry Schizophrenia Consultation Clinic**
Email:	psychiatryconsultation@jhu.edu
Fax Number:	**(443) 769-1217**

Patient Name:	Patient Date of Birth:

Pre-Consultation Questions

1. Please list your current clinicians?

Specialty type	Provider's Name	Phone Number	Fax Number
Psychiatrist			
Therapist			
PCP Primary Care Provider			
Other:			

2. How have you been doing for the last few weeks?

3. Who recommended that you obtain a consultation?

4. How did you learn about our consultation clinic?

Patient Questionnaire - Schizophrenia 2nd Opinion Consultation

5. In one sentence, what do you see as your most important problems or symptoms?

6. When did you first become ill? What are your symptoms?

7. What questions you want to be sure are addressed at the end of the consultation?

8. Where do you live now, and who do you live with?

9. Where did you attend school? What was the highest-grade level that you completed? How did you do in school? Did you have friends? Did you participate in activities?

10. Are you currently employed or in school?

11. Describe the role of religion in your life.

12. Have you been married or had a long-term relationship? Do you have children?

13. Describe your personality. How would friends or family describe you?

14. Do you have hobbies or activities that you enjoy? What are your goals over the next few years?

Patient Questionnaire - Schizophrenia 2nd Opinion Consultation

15. Were there any difficulties during your mother's pregnancy with you, during or right after your birth?

16. Did you have any health or development problems, like delays in walking or talking, prior to starting school?

17. Describe in detail the history of your symptoms, including the type of symptoms that you experience, a time line of when symptoms began and how they have changed over time.

18. Describe any legal difficulties that you have had, such as arrest, time in jail, or law suits. Are you facing any legal charges or are you involved in law suits or other legal matters now?

19. Please complete the substance use section below

Use Type	Please check the box that applies to you/enter info
Do you drink alcohol?	No ☐ Yes ☐ How many glasses do you drink in a typical week?
Do you use tobacco products?	Cigarettes ☐ Cigars ☐ Vapes ☐ Chewing ☐ Other:
Do you use marijuana?	No ☐ Yes ☐
Do you use other drugs? If yes, please list them.	No ☐ Yes ☐

Patient Questionnaire - Schizophrenia 2nd Opinion Consultation

20. List any medical problems that you have, including past surgeries or head injuries.

Medical Diagnosis/Surgical Procedure	Date Diagnosed/ Date Surgical Procedure was Preformed

21. List any allergies that you have to medications

Patient Questionnaire - Schizophrenia 2nd Opinion Consultation

22. List your medications below

***Be sure to include ALL prescription drugs over-the-counter drugs, vitamins, and herbal supplements**

Name of Medication	Route	Dosage	Frequency	Start Date	Stop Date	Symptoms/Notes
	Select Or		Select On			
	Select On		Select On			
	Select Or		Select On			
	Select On		Select On			
	Select On		Select On			
	Select On		Select On			
	Select On		Select On			
	Select On		Select On			
	Select On		Select On			

Description Key:

Name of the medication = Name of the medication
Route = How do you take the medication?
Dosage = How much do you take? (Ex: 10 MG.)
Frequency = How often do you take the medication? (Ex: Daily)

Start Date = When did you start taking the medication?
Stop Date = When did you stop taking the medication? Leave blank if you are still taking it.
Symptoms/Notes = Any notes or symptoms that we should know about that medication

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Please provide any additional notes in this section.