Welcome!

Patient's ID sticker will go here

Johns Hopkins Hospital Division of Gastroenterology
Patient Questionaire

Please fill out and bring to the clinic at the time of your appointment.

Patient's Name: _____ Date: _____

Social Security #: _____ Johns Hopkins History #: _____ (if known)

Who referred you to the Johns Hopkins Gastroenterology Clinic?

Physician's Name: _____

Address: _____

Telephone #: _____ Fax #: _____

Other Physicians to receive copies of your evaluation:

Physician's Name: _____

Address: _____

Telephone #: _____ Fax #: _____

Physician's Name: _____

Address: _____

Telephone #: _____ Fax #: _____

What is the primary medical problem for which you seek evaluation information or treatment? _____

_____

_____

PAST HISTORY

Indicate if you have had any of the following:

❑ Rheumatic fever ❑ Measles ❑ Mumps ❑ Heart Murmur ❑ Anemia ❑ Hepatitis ❑ Diabetes ❑ Heart Attack ❑ Lung Disease
❑ Kidney disease ❑ Cancer ❑ Stroke ❑ Tuberculosis ❑ Mental disease

What other illness have you had? (Name and approximate date) _____

_____

_____

Have you had any surgery? (Type of operation and approximate date) _____

_____

_____

Have you had any allergy to any medications?

Name: _____ Type of reaction: _____

CURRENT MEDICATIONS (For each, include: Name, Dose, Frequency)

In the past 3 years have you had a:

❑ yes ❑ no Stool tested for blood

❑ yes ❑ no Flexible sigmoidoscopy or colonoscopy

❑ yes ❑ no Blood cholesterol level

❑ yes ❑ no Prostatic specific antigen test (PSA)

❑ yes ❑ no Chest X-ray

❑ yes ❑ no Electrocardiogram (EKG)

❑ yes ❑ no Mammogram

❑ yes ❑ no Pap Smear and Pelvic Exam

❑ yes ❑ no CT scan of abdomen

❑ yes ❑ no Liver biopsy

REVIEW OF SYSTEMS

Do you have or have had any of the following problems?

General: ❑ poor apetite ❑ weight loss ❑ weight gain ❑ easy fatigabilty ❑ transfussion ❑ anxiety ❑ fever or abnormal sweating ❑ itching ❑ depression

Head: ❑ eye trouble ❑ hearing disorder ❑ sore tongue or mouth ❑ yellow eyes

Neck: ❑ goiter ❑ lumps or masses

Chest: ❑ chest pain ❑ shortness of breath ❑ palpitations ❑ asthma ❑ chronic cough ❑ high blood pressure

GI: ❑ heart burn ❑ difficulty swallowing ❑ indigestion ❑ milk intolerance ❑ persistent nausea or vomiting ❑ vomiting blood ❑ passing blood ❑ abdominal pain ❑ diarrhea ❑ constipation ❑ abdominal swelling

GU: ❑ difficulty with urination ❑ blood in urine ❑ dark urine ❑ kidney stones

Females Only: Any trouble with menstrual periods? ❑ yes ❑ no

Last mentrual period: / / Contraceptive use: Estrogen replacement?

Extremities: ❑ arthritis ❑ swollen legs ❑ cold sensitivity

Neurologic: ❑ recurrent headaches ❑ loss of consciousness ❑ seizures ❑ loss of memory ❑ confusion ❑ tremor ❑ weakness or numbness of face or exremities

Current weight: Lowest weight: Highest weight;

Immunizations: ❑ Influenza ❑ Tetanus/diphtheria ❑ pneumonia ❑ hepatitis B

PERSONAL HISTORY:

Education - How many years of school have you completed?

Occupation - Current employment status: ❑ retired ❑ unemployed ❑ homemaker ❑ employed:

Current occupation: Previous occupation:

Disability - Are your disabled? ❑ yes ❑ no Cause:

Abuse - Have you ever been physically, sexually or emotionally abused? ❑ yes ❑ no

Have you used any of the following substances?

Substance	Current Use	Previous Use	Type/Amount	How long/frequency	If stopped, when
Caffeine (coffee, tea, soda)					
Tobacco					
Alcohol (beer, wine, liquor)					
Recreational/street drugs					

Marital status: ❑ single ❑ married ❑ separated ❑ divorced ❑ widowed

Current spouse: ❑ N/A ❑ alive ❑ health problems or cause of death

If alive, current employment status: ❑ retired ❑ unemployed ❑ homemaker ❑ employed Current occupation: _____

Do you exercise regularly? ❑ yes ❑ no Type: _____ Frequency: _____

Sleep: Do you have difficulty falling asleep? ❑ yes ❑ no Do you awaken early in the morning without apparent cause? ❑ yes ❑ no

FAMILY HISTORY

Family History		**If Living**		**If Deceased**	
	Sex	**Age**	**Health**	**Age at death**	**Cause**
Father					
Mother					
Siblings	M F				
(You may omit names)	M F				
	M F				
	M F				
	M F				
Husband/Wife					
Children (circle sex)	M F				
	M F				
	M F				
	M F				
	M F				
	M F				

Some names may be used for either men or women, please circle sex for each brother, sister, son or daughter.

Do you know of any blood relative who has or had: (Check and give relationship)

Cancer
- ❑ Breast _____
- ❑ Colon _____
- ❑ Ovary _____
- ❑ Uterus _____
- ❑ Other type, if known: _____

- ❑ Epilepsy _____
- ❑ Migraine _____
- ❑ Mental illness _____
- ❑ Alcohol or drug abuse _____
- ❑ Stroke/TIA _____
- ❑ High blood pressure _____

- ❑ High cholestrol/triglyycerides _____
- ❑ Heart disease _____
- ❑ Diabetes _____
- ❑ Ulcer (duodenal or gastric) _____
- ❑ Crohn's disease _____
- ❑ Irritable bowel syndrome _____

- ❑ Liver disease _____
- ❑ Kidney disease _____
- ❑ Lung disease _____
- ❑ Genetic disorder _____
- ❑ Goiter _____
- ❑ Arthritis _____

Reviewing Physician _____ Date: _____