JOHNS HOPKINS
MEDICINE

NEW PATIENT HISTORY QUESTIONNAIRE

Neurology

Physician Initials_____ Date_____

PATIENT INFORMATION					
NAME		***JHH#***			
ADDRESS		***DOB#***		***AGE***	
HOME PH		***DAY PH***			
CELL PH		***EMAIL***			

Who is your ***REFERRING PHYSICIAN***? (The doctor who referred you to Johns Hopkins Neurology.) *Please be sure to include the fax #, so we can fax reports.*			
NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	

Who is your ***PRIMARY CARE PHYSICIAN***? (The doctor who coordinates your care.) *Please be sure to include the fax #, so we can fax reports.*			
NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	

We will send copies of your reports to the *Referring Physician* and *Primary Care Physician* listed above. Is there anyone else who should receive copies?			
NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	
NAME		***SPECIALTY***	
ADDRESS		***PHONE***	
		FAX	

Patient Name:_____DOB:_____

CHIEF COMPLAINT Please briefly describe the purpose of this visit, and specifically what you want to achieve from it.	**Physician Notes**
HISTORY OF PRESENT ILLNESS	**NOTES**
What problems are you experiencing?	
What part(s) of your body does this problem affect?	
How long have you had this problem?	
How often does the problem occur?	
Does the problem occur at a particular time of day? If so, when?	
How long does the problem last?	
How severe is the problem? Does it affect your activities of daily living?	
Does anything help make the problem go away? If so, what?	
Does anything seem to make the problem worse? If so, what?	
List all the tests you have had for this problem (Blood, Urine, MRI, CT Scan, EMG, EEG).	
List the prior treatment or surgery for this problem and if has helped?	
How much pain have you had in the past week? (no pain 0 to maximal 10) 0……1……..2.....3……..4.....5.....6.....7.....8……..9……..10	

Patient Name:_____DOB:_____

REVIEW OF SYSTEMS - GENERAL Please check any conditions you have experienced.							
GENERAL		**EARS, NOSE, MOUTH, THROAT**		**CARDIOVASCULAR**		**HEMATOLOGIC/ENDOCRINE**	
Y/N	Altered taste/ smell	Y/N	Balance problem	Y/N	Angina	Y/N	Blood disorder
Y/N	Change in appetite	Y/N	Dizziness	Y/N	Chest pain	Y/N	Diabetes
Y/N	Weight loss	Y/N	Ringing in ears	Y/N	Chest pressure	Y/N	Other Endocrine disorder
Y/N	Weight gain	Y/N	Hearing loss	Y/N	Fainting	Y/N	Sickle Cell Disease
Y/N	Unable to sleep	Y/N	Trouble breathing through nose	Y/N	Heart Failure	Y/N	Thyroid Disease
Y/N	Excessive sleepiness	Y/N	Nose bleeds / discharge	Y/N	Heart Murmur	Y/N	Enlarged lymph nodes
Y/N	Snoring	Y/N	Sinus disease	Y/N	High blood pressure	Y/N	HIV exposure
Y/N	Skip breathing in sleep	Y/N	Mouth sores	Y/N	Low blood pressure	Y/N	AIDS
Y/N	Fatigue	Y/N	Sore throat	Y/N	Shortness of breath	Y/N	Dry eyes or dry mouth
Y/N	Fever	Y/N	Trouble swallowing	Y/N	Leg swelling	Y/N	Miscarriages
MUSCULOSKELETAL		**EYES**		**GASTROINTESTINAL**		**RESPIRATORY**	
Y/N	Low back pain	Y/N	Blurred vision	Y/N	Abdominal pain	Y/N	Bronchitis
Y/N	Neck pain	Y/N	Double vision	Y/N	Constipation	Y/N	Emphysema
Y/N	Joint pain	Y/N	Glaucoma	Y/N	Diarrhea	Y/N	Pneumonia
Y/N	Joint swelling	Y/N	Cataracts	Y/N	Gastritis	Y/N	Tuberculosis
Y/N	Joint replacement	Y/N	Macular degeneration	Y/N	Hepatitis	Y/N	Chronic cough
SKIN		**PSYCHIATRIC**		Y/N	Hiatal Hernia		**URINARY**
Y/N	Breast disease	Y/N	Anxiety	Y/N	Rectal bleeding	Y/N	Increased frequency
Y/N	Skin rash	Y/N	Depression	Y/N	Ulcer	Y/N	Incontinence
Y/N	Botox injection	Y/N	Trouble concentrating	Y/N	Vomiting	Y/N	Sexual dysfunction
REVIEW OF SYSTEMS – NEUROLOGIC							
Y/N	Confusion	Y/N	Clumsiness	Y/N	Choking	Y/N	Difficulty with smelling
Y/N	Difficulty Concentrating	Y/N	Facial numbness / tingling	Y/N	Difficulty chewing	Y/N	Double vision
Y/N	Dizziness	Y/N	Numbness - arms (L/ R/ Both)	Y/N	Difficulty tasting	Y/N	Trouble swallowing
Y/N	Hallucinations	Y/N	Numbness - legs (L/ R/ Both)	Y/N	Drooling	Y/N	Fainting spells
Y/N	Headache	Y/N	Poor balance	Y/N	Hoarseness	Y/N	Vertigo/Dizziness
Y/N	Lethargy	Y/N	Poor coordination	Y/N	Incontinence- bowel	Y/N	Muscle Twitching
Y/N	Memory problems	Y/N	Speech difficulty	Y/N	Incontinence- bladder	Y/N	Loss of muscle bulk
Y/N	Personality change	Y/N	Stiffness in limbs	Y/N	Nausea	Y/N	Any falls in past 1 yr.
Y/N	Seizures	Y/N	Trouble walking	Y/N	Shooting Pains		
Y/N	Increase/Decrease in sweating in limbs	Y/N	Weakness - arms (L/ R/ Both)	Y/N	Tingling sensation		
Y/N	Leg Discomfort @ Night	Y/N	Weakness - legs (L/ R/ Both)	Y/N	Shortness of breath		

ALL OTHERS NEGATIVE _____

PAST MEDICAL HISTORY

Patient Name:_____DOB:_____

Please list all medical problems and hospitalizations you had in the past with approximate dates.
(Use separate page if necessary.)

MEDICAL PROBLEMS	DATE	MEDICATIONS* Please list all current medications on last page (Outpatient Medication List)	RESULT

SURGERIES (Please list all operations you have had, with approximate dates)

PROCEDURE	DATE	SURGEON	RESULT

Have you ever had a problem with anesthesia? __Yes __No
If so, what substance and what complication?

Have you ever had a blood transfusion or received blood products or growth hormone? Yes __No____
If so, when? Why?

Patient Name:_____DOB:_____

FAMILY HISTORY							
	Father	Mother	Father's Parents	Mother's Parents	Brothers / Sisters	Children	NOTES
Arthritis							
Bleeding disorder							
Cancer							
CNS Tumors							
Dementia							
Diabetes							
Epilepsy							
Heart Disease							
Hypertension							
Kidney Disease							
Lupus							
MS							
Neuropathy/ALS/muscular dystrophy							
Stroke							
Thyroid Disease							

GYN/ OB MEDICAL HISTORY

LAST MENSTRUAL PERIOD: ARE YOU POST-MENOPAUSAL? __ YES __NO DATE OF MENOPAUSE:

DATE OF LAST GYNECOLOGICAL EXAM WITH PAP SMEAR: RESULT:

DATE OF LAST MAMMOGRAM: RESULT:

HAVE YOU EVER BEEN PREGNANT? __ YES __NO IF SO, HOW MANY TIMES? _____
HOW MANY DELIVERIES HAVE YOU HAD? _____ HAVE YOU EVER HAD A MISCARRIAGE? __ YES __NO

Patient Name:_____DOB:_____

SOCIAL HISTORY

HOW OLD ARE YOU? HEIGHT: WEIGHT: ARE YOU A TWIN? Y N

ARE YOU: __ LEFT-HANDED __ RIGHT-HANDED __ BOTH

ARE YOU: __ SINGLE __ MARRIED __ WIDOWED __ SEPARATED __ DIVORCED

WHAT IS YOUR OCCUPATION?

DO YOU LIVE: __ ALONE __ WITH SPOUSE __ WITH ROOMMATE __ WITH PARENTS/SIBLINGS _OTHER_

WHAT IS YOUR HIGHEST LEVEL OF EDUCATION?
__ GRADE SCHOOL __ HIGH SCHOOL __ VOCATIONAL SCHOOL __ COLLEGE __ GRADUATE SCHOOL

WHAT ARE YOUR HOBBIES?

DO YOU SMOKE? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _____
HAVE YOU EVER SMOKED? __YES __NO HOW MUCH? _____ PER _____ FOR HOW LONG? _____
WHEN DID YOU STOP?

DO YOU DRINK ALCOHOL? __YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _____
HAVE YOU EVER DRUNK ALCOHOL? __ YES __NO HOW MUCH? ___ PER ___ FOR HOW LONG? _____
WHEN DID YOU STOP?

Patient Name:_____DOB:_____

The Johns Hopkins Hospital
600 North Wolfe Street
Baltimore, MD 21287

OUTPATIENT MEDICATION LIST

Patient Name:

JHH #

❑ Prescriber has made edits to EPR Medication List.
❑ Staff needs to make edits to EPR Medication List.
This box for hospital use only.

ALLERGIES: Please list any medication allergies and your reaction to these medications:

1._____ 3._____

2. _____4. _____

MEDICATIONS (include over-the-counter and herbal medications)	DOSE (e.g., strength, # of pills or drops)	ROUTE (e.g., by mouth, injection, inhaled, orn skin)	FREQUENCY (how often)
Example: Vitamin C	*500 mg*	*By mouth*	*Once a day*
1.			
2.			
3.			
4.			
5			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

Please use additional sheet for more medications.