The Johns Hopkins Division of Facial Plastic & Reconstructive Surgery

Department of Otolaryngology-Head & Neck Surgery

JOHNS HOPKINS MEDICINE

NEW PATIENT INFORMATION SHEET

Name _____ D.O.B. _____ Date _____

JH History Number: _____ S.S.N: _____

Address: _____

Home #: _____ Work/Cell/Daytime #: _____

Email: _____

How were you referred to us?
Please check all that applies

- □ Physician (please list their name) _____
- □ Friend (please list their name) _____
- □ Our web site _____
- □ Internet search engine _____
- □ Print advertising (please list the publication) _____

Please provide the name and address of your Primary Care Provider as well as the Physician who referred you. Please include the address, telephone, and fax number.

Current Occupation: _____

Prior Occupations: _____

Who lives with you: _____

May the doctor discuss your health with that person? Yes No

Are you: Single Married Long-Term Relationship Divorced Widowed

What is the reason for your visit? _____

What have you been told is the cause of your problem? _____

Have you had any tests done to evaluate this problem? If so, what tests were done and what were the results?

Medicine & Food Allergies: (Please include name and type of reaction) _____

Current Medications: (Please list all including name, dosage, and frequency) _____

Do You Take? (Circle if yes) Aspirin Coumadin Lovenox Ibuprofen/Motrin/Vioxx Glucophage

Insulin Contraceptives/Other Hormones Herbs Anti-HIV/Anti-TB Med Prednisone Immune Suppression

Do You Smoke? Yes No If yes, how much and how long? _____

Do You Drink Alcohol? Yes No If yes, how much? _____

Have you ever used? Injection Drugs Cocaine Narcotics LSD Other recreational drugs

List All Surgeries You Have Had: (Please include type of operation, date, why, surgeon)

List All Your Medical Problems: (Please includ name/city of cardiologists or other specialists if any)

Are you interested in discussing or learning about any of the following: (Please check all that apply)

- □ Facial Enhancement
- □ Facial Wrinkles
- □ Drooping Eyelids
- □ Lip Enhancement
- □ Facial or Neck Scars
- □ Improving the Appearance of your Hair
- □ Improving the Function or Appearance of Your Nose
- □ Botox / Other In-Clinic Cosmetic Procedures
- □ Puffy or Tired Looking Eyes
- □ Sagging Skin of the Face or Neck
- □ Products to Improve your Skin Quality and Appearance

SYSTEM REVIEW (please circle appropriate answer)

Constitutional Symptoms

Good general health lately	No	Yes
Recent weight change	No	Yes
Fever	No	Yes
Fatigue	No	Yes
Headaches	No	Yes

Eyes

Eye disease or injury	No	Yes
Blurred or double vision	No	Yes
Glaucoma	No	Yes

Ears/Nose/Mouth/Throat

Hearing loss	No	Yes
Ringing	No	Yes
Earaches or drainage	No	Yes
Inner ear disease	No	Yes
Ear pain, fullness, popping	No	Yes
Facial pain, pins, needles	No	Yes
Facial numbness, weakness	No	Yes
Chronic sinus problems	No	Yes
Rhinitis	No	Yes

Cardiovascular

Heart disease	No	Yes
Chest pain	No	Yes
Palpitations	No	Yes
Shortness of breaths	No	Yes

Respiratory

Chronic or frequent cough	No	Yes
Asthma or wheezing	No	Yes

Gastrointestinal

Loss of appetite	No	Yes
Change in bowel movement	No	Yes
Nausea or vomiting	No	Yes
Frequent diarrhea	No	Yes
Constipation	No	Yes
Peptic ulcer	No	Yes

Genitourinary

Frequent urination	No	Yes
Blood in urine	No	Yes
Incontinence or dribbling	No	Yes
Kidney stones	No	Yes

Integumentary (Skin, Breast, etc.)

Rash or Itch	No	Yes
Change in skin color	No	Yes
Varicose veins	No	Yes
Breast Lump	No	Yes

Neurological

Frequent headaches	No	Yes
Lightheaded or dizzy	No	Yes
Seizures	No	Yes
Tremors	No	Yes
Head injury	No	Yes

Psychiatric

Memory loss or confusion	No	Yes
Depression	No	Yes
Anxiety	No	Yes
Eating Disorder	No	Yes

Endocrine

Thyroid disease	No	Yes
Diabetes	No	Yes
Excessive thirst/urination	No	Yes
Heat or cold intolerance	No	Yes
Skin becoming dry	No	Yes

Hematologic/Lymphatic

Slow to heal after cuts	No	Yes
Bleeding, bruising tendency	No	Yes
Anemia	No	Yes
Phlebitis	No	Yes
Enlarged glands	No	Yes

Allergic/Immunologic

History of skin reaction or other adverse reaction to:

Penicillin or other antibiotics	No	Yes
Narcotics	No	Yes
Aspirin, other pain remedies	No	Yes
Known food allergies	No	Yes

Musculoskeletal

Joint pain, stiffness, swelling	No	Yes
Muscle weakness	No	Yes
Difficulty walking	No	Yes
Back Pain	No	Yes