



- Johns Hopkins Hospital Johns Hopkins Community Physicians
- Johns Hopkins Bayview Other: _____



Neurosurgery New Patient History Questionnaire

Patient Identification Information

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, and reports of significant medical problems.

Full Name _____ DOB _____ Age _____

Address: _____

Email _____

Phone Numbers: (H) _____ (W) _____ (C) _____

Emergency Contact: _____ Phone # _____

REFERRING PHYSICIAN INFORMATION

Physician Name _____ Specialty: _____

Address _____

Phone _____ Fax Number: _____

Is there anyone else who should receive a copy of the clinic report? (i.e. Primary care physician)

Physician Name _____ Specialty: _____

Address _____

Phone _____ Fax Number _____

PRESENT ILLNESS

1. What is the reason for your visit today? _____

2. What symptoms are you currently experiencing? _____

3. How long do the symptoms last? _____ How often do they occur? _____

4. How severe are the symptoms on a scale of 0(no pain) 10(worst imaginable)? ____ How severe is the pain? ____

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: _____



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PAST MEDICAL HISTORY

Please list all operations you have had in the past with approximate dates. (Example: Colectomy March 2010; Lumpectomy June 1996, etc.)

Please list all current medical problems and major illness you have had with approximate dates: (Example: Diabetes, Diagnosed April 2004, High Blood Pressure, Diagnosed 1995, etc.)

Have you ever had a blood transfusion or received blood products? Yes No

Have you had any problems with anesthesia? Yes No

If yes, please explain: _____

Are you: Left handed Right handed Ambidextrous

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 _____

Please list any drug allergies: _____

Please list any food allergies: _____



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REVIEW OF SYSTEMS

Please check the medical condition(s) below which apply to you either now or in the past.

Cardiovascular

- Chest pain/pressure, Fainting, Heart attack, Heart defect, Heart murmur, High blood pressure, Low blood pressure, Leg Swelling

Constitutional

- Altered taste/smell, Cancer, Change in appetite, Excessive sleepiness, Fatigue, Fever, Depression, Anxiety, Recent sore throat, Sleep apnea, Weight loss or gain

Ears, Nose, & Throat

- Hearing loss, Mouth sores, Ringing in ears, Sinus disease, Trouble swallowing

Eyes

- Blurred vision, Cataracts, Double vision, Glaucoma, Macular degeneration, Peripheral vision issue, Visual impairment

Gastrointestinal

- Black stool, Constipation, Diarrhea, Gall bladder problems

- Ulcer, Vomiting

Skin

- Birth marks, Psoriasis, Skin rashes, Melanoma

Respiratory

- Asthma, Bronchitis, Chronic cough, COPD, Emphysema, Pneumonia, Shortness of breath, Trouble breathing, Tuberculosis, Wheezing

Musculoskeletal

- Connective tissue disorder, Low back pain, Neck pain, Joint pain, Joint replacement, Joint swelling

Genitourinary

- Blood in urine, Change in habits, Infections in urine, Kidney disease, Kidney stones, Loss of control, Painful urination, Urinary urgency, Vaginal bleeding

Hemilymphatic/Endocrine

- Anemia, Blood disorder, Circulatory problems, Diabetes, Dry eyes/mouth, Endocrine disorder, Low blood sugar, Lymph node swelling, Hepatitis, HIV/AIDS, Pituitary disorder, Sickle cell disease, Thyroid disease

Neurological

- Balance difficulty, Choking, Clumsiness, Concussion, Confusion, Concentration difficulty, Dizziness, Drooling, Falls, Hallucinations, Headache, Loss of consciousness, Memory problems, Muscle twitching, Nausea, Numbness, Personality change, Seizure, Shooting pains, Smelling difficulty, Stroke, Tasting difficulty, Tingling sensation, Vertigo, Walking difficulty

For Providers Only: All others negative [] Initial _____



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SOCIAL HISTORY

Gender: Male Female Height: 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 Spouse Children Parents/sibling Do you smoke? Yes No If you smoked and quit, when did you quit? If yes, how many packs/day? How long have you been smoking? Do you drink alcohol? Yes No If, yes how many drinks/week? Do you drink caffeinated drinks (tea, coffee, soda, etc) Yes No If Yes, how many drinks/week?

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 Relation Age Condition Relation Age Condition Relation Age Condition Relation Age Condition Relation Age Condition Do you have children? Yes No If yes, age(s) and condition

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD. THANK YOU!

COMPLETED BY: PRINTED SIGNATURE DATE TIME

REVIEWED BY: M.D. M.D.

