



**JOHNS HOPKINS  
BAYVIEW**

**NEUROLOGY / NEUROSURGERY**

**PATIENT HISTORY QUESTIONNAIRE**

Addressograph

**PATIENT INFORMATION**

<b>PATIENT</b>		<b>JHBMC#</b>	
<b>ADDRESS</b>		<b>DATE OF BIRTH</b>	<b>AGE</b>
		<b>SOCIAL SECURITY NUMBER</b>	
<b>HOME PHONE #</b>		<b>DAY PHONE #</b>	

Who is your **REFERRING PHYSICIAN?** (The doctor who referred you to Johns Hopkins Bayview Neurology.) Please be sure to include street address and zip code so we can mail reports.

<b>NAME</b>		<b>SPECIALTY</b>	
<b>ADDRESS</b>		<b>PHONE</b>	
		<b>FAX</b>	

Who is your **PRIMARY CARE PHYSICIAN?** (The doctor who coordinates your care.) Please be sure to include street address and zip code so we can mail reports.

<b>NAME</b>		<b>SPECIALTY</b>	
<b>ADDRESS</b>		<b>PHONE</b>	

If you were not referred to JOHNS HOPKINS BAYVIEW NEUROLOGY by a doctor, who suggested you come here, or how did you find out about our department?

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?

<b>NAME</b>		<b>SPECIALTY</b>	
<b>ADDRESS</b>		<b>PHONE</b>	
		<b>FAX</b>	
<b>NAME</b>		<b>SPECIALTY</b>	
<b>ADDRESS</b>		<b>PHONE</b>	
		<b>FAX</b>	

<b>CHIEF COMPLAINT</b> Please briefly describe the purpose of this visit.	<b>Physician Notes</b>
<b>HISTORY OF PRESENT ILLNESS</b>	<b>NOTES</b>
What signs or symptoms are you experiencing?	
What part (s) of your body does this problem affect?	
How long have you had this problem?	
How often do the symptoms occur?	
Do symptoms occur at a particular time of day? If so, when?	
How long do the symptoms last?	
How severe is the problem?	
Does anything help make the problem go away? If so, what?	
Does anything seem to make the problem worse? If so, what?	
Have you had prior treatment or surgery for this problem? If so:  What:  By whom:  Result:	

**REVIEW OF SYSTEMS - GENERAL**

Please circle yes or no to indicate if you have any of the conditions below.

<b>CONSTITUTIONAL</b>		<b>EARS, NOSE, MOUTH, THROAT</b>		<b>CARDIOVASCULAR</b>		<b>BLOOD/LYMPH DISORDERS</b>	
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 or gain	Y/N	Ringing in ears	Y/N	Chest pressure	Y/N	Endocrine disorder
Y/N	Unable to sleep	Y/N	Hearing loss	Y/N	Fainting	Y/N	Sickle Cell Disease
Y/N	Excessive sleepiness	Y/N	Trouble breathing through nose	Y/N	Heart Failure	Y/N	Thyroid Disease
Y/N	Fatigue	Y/N	Nose bleeds/discharge	Y/N	Heart Murmur	Y/N	Enlarged lymph nodes
Y/N	Fever	Y/N	Sinus disease	Y/N	High blood pressure	Y/N	HIV
		Y/N	Mouth sores	Y/N	Low blood pressure	Y/N	AIDS
		Y/N	Sore throat	Y/N	Shortness of breath	Y/N	
		Y/N	Trouble swallowing	Y/N	Leg swelling	Y/N	
<b>MUSCULOSKELETAL</b>		<b>EYES</b>		<b>GASTROINTESTINAL</b>		<b>RESPIRATORY</b>	
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	Hepatitis	Y/N	Chronic cough
<b>INTEGUMENTARY</b>		<b>PSYCHIATRIC</b>		Y/N	Hiatal Hernia		
Y/N	Breast disease	Y/N	Anxiety	Y/N	Rectal bleeding		
Y/N	Skin rash	Y/N	Depression	Y/N	Ulcer		
		Y/N	Trouble concentrating	Y/N	Vomiting		
<b>REVIEW OF SYSTEMS - NEUROLOGICAL</b>							
Y/N	Confusion	Y/N	Clumsiness	Y/N	Choking	Y/N	Blurred vision
Y/N	Difficulty concentrating	Y/N	Facial numbness/tingling	Y/N	Difficulty chewing	Y/N	Decreased hearing
Y/N	Dizziness	Y/N	Numbness - arms (L / R / B)	Y/N	Difficulty tasting	Y/N	Diplopia (double vision)
Y/N	Hallucinations	Y/N	Numbness - legs (L / R / B)	Y/N	Drooling	Y/N	Dysphagia (difficulty swallowing)
Y/N	Headache	Y/N	Poor balance	Y/N	Hoarseness	Y/N	Syncope (fainting)
Y/N	Lethargy	Y/N	Poor coordination	Y/N	Incontinence - bowel	Y/N	Tinnitus (ringing in ears)
Y/N	Memory problems	Y/N	Speech difficulty	Y/N	Incontinence - bladder	Y/N	Trouble with smell
Y/N	Personality change	Y/N	Stiffness	Y/N	Nausea	Y/N	Vertigo
Y/N	Spells	Y/N	Trouble walking	Y/N	Pain		
		Y/N	Weakness - arms (L/ R/ B)	Y/N	Vomiting		
		Y/N	Weakness - legs (L/ R/ B)				

L = Left R = Right B = Both Y = Yes N = No

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### CURRENT MEDICATIONS

Please list all medications you take, including herbal and over the counter drugs.

DRUG	DOSE/FREQUENCY	PRESCRIBED BY	TAKEN SINCE

Do you take aspirin or any medicines that contain aspirin?  Yes  No

### DRUG ALLERGIES AND ADVERSE DRUG REACTIONS

Are you allergic to any medications? If so, please list the medications and your reaction to it.

MEDICATION	REACTION	MEDICATION	REACTION

### PAST MEDICAL HISTORY

#### 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?  Yes  No  
If so, when? Why?

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

**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Brothers/ Sisters	Children	NOTES
Arthritis							
Bleeding disorder							
Cancer							
Central Nervous System Tumors							
Dementia							
Diabetes							
Epilepsy							
Heart disease							
Hypertension							
Kidney disease							
Neuromuscular disease							
Stroke							
Thyroid Disease							

**GYN/OB MEDICAL HISTORY - FOR FEMALE PATIENTS ONLY**

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

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### SOCIAL HISTORY

ARE YOU:  SINGLE  MARRIED  WIDOWED  SEPARATED  DIVORCED

IF YOU ARE MARRIED, WHAT IS YOUR SPOUSE'S OCCUPATION?

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

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 DRANK ALCOHOL?  Yes  No HOW MUCH? \_\_\_\_\_ PER \_\_\_\_\_ FOR HOW LONG? \_\_\_\_\_

WHEN DID YOU STOP? \_\_\_\_\_

PLEASE TELL US ANYTHING ELSE ABOUT YOURSELF OR YOUR CONDITION THAT YOU THINK WE SHOULD KNOW.

THIS FORM IS CONFIDENTIAL AND PART OF YOUR MEDICAL RECORD.

THANK YOU!

NAME OF PERSON COMPLETING THIS FORM: \_\_\_\_\_

REVIEWED BY:

\_\_\_\_\_  
SIGNATURE M.D. DATE: \_\_\_\_\_

\_\_\_\_\_  
PRINTED M.D. DATE: \_\_\_\_\_