JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
BAYVIEW MEDICAL CENTER

4004657508-321

AMBULATORY CARE CENTER
NEW PATIENT ASSESSMENT

Addressograph

PATIENT INFORMATION:

Patient's Name: _____ DOB: _____

Name of person filling out this form: _____ Today's Date: _____

How did you hear about this clinic: _____

Reason for visit: (Check one) **Consult** _____ **Establish Primary Care** _____

Comments or concerns about patient's HEALTH: _____

_____

MEDICAL HISTORY:

Have you had any of the following conditions?	YES	NO	COMMENTS
Diabetes			
High Blood Pressure			
Heart Disease			
Stroke			
Memory Problems			
Cancer			
Emphysema			
Kidney Disease			
Pneumonia			
Arthritis			
Osteoporosis/Broken Bones			
Other (please list)			

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WHAT SURGERIES HAVE YOU HAD:

TYPE	DATE	HOSPITAL

LIST ALL HOSPITALIZATIONS WITHIN THE LAST 5 YEARS:

HOSPITAL	WHY?	WHEN

PSYCHIATRIC HISTORY:

Have you had any nervous or psychiatric illness	YES	NO	COMMENTS

LIST PRIMARY (FAMILY DOCTOR) & OTHER SPECIALISTS:

NAME	ADDRESS

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CURRENT MEDICATIONS: PLEASE BRING ALL OF YOUR MEDICATIONS WITH YOU

Name of medication (Prescription and Non-prescription) (Use back of sheet if needed)		

MEDICATION ALLERGIES	COMMENTS

ADVANCE DIRECTIVES:

(Use back of sheet if needed)	YES	NO	COMMENTS
Have you appointed a durable power of attorney for health care decisions?			
Do you have a living will?			
If you were unable to make your own health care decisions, who would you trust to make these decisions on your behalf?	Name of person: _____ Address: _____ Phone#: _____ Relationship: _____		
Do you have any opinions about cardiac resuscitation, mechanical ventilation, feeding tubes or other medical interventions that your doctor should know about.			

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HEALTH MAINTENANCE:

	DATE	YES	NO	COMMENTS
When was your last eye exam?				
When was your last dental exam?				
When was your last tetanus shot?				
Have you taken the pneumonia vaccine?				
Do you take the yearly flu shot?				
Has your stool been checked for blood?				
Have you had a sigmoidoscopy or colonoscopy?				
Has your cholesterol been checked?				
Do you engage in any exercise?				
Do you follow any special diet?				
Has your bone mineral density been measured?				
FOR WOMEN				
When was your last mammogram/ breast examination?				
When was your last pelvic exam/pap smear?				
Have you ever taken hormones, i.e., estrogen?				
FOR MEN				
When was your last prostate exam?				

FAMILY HISTORY:

PLEASE LIST CURRENT AGE AND HEALTH STATUS OF FAMILY MEMBERS (IF DECEASED, LIST AGE AT DEATH AND CAUSE)	
Mother	
Father	
Brother(s)	
Sister(s)	
Spouse	
Children	

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SOCIAL HISTORY:

Education (highest grade completed)			
Work history			
Are you retired	If so, how long?		
What are your current activities?			
What is your current living situation?	Type of house?	With whom?	
Do you smoke cigarettes?	Current:	Past years, but quit:	Never:
Have any of your friends or relatives died recently?			
Are you having any severe financial difficulties?			

FUNCTIONAL ASSESSMENT:

Do you have any problems with:	YES	NO	COMMENTS
Walking			
Leakage of urine or feces			
Bathing yourself			
Dressing yourself			
Feeding yourself			
Getting out of bed or chair			
Using the telephone			
Driving a car			
Using public transportation			
Doing your own shopping			
Doing your own cooking			
Doing your own cleaning			
Managing your own finances			
Taking your medications			

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OVERALL HEALTH:

How do you feel? (check one)	Excellent ( )	Good ( )	Fair ( )	Poor ( )

REVIEW OF SYSTEMS:

	YES	NO	COMMENTS
Have you had a recent change in your weight?			
Any episodes of falling?			
Problems with dizziness?			
Are you depressed, sad or feel blue?			
Any trouble sleeping?			
Have you had any problems with money?			
Problems with hearing?			
Problems with vision?			
Problems with teeth or dentures?			
Any problems with cough?			
Chest pain, discomfort, or heaviness?			
Shortness of breath?			
Constipation, diarrhea, or change in bowel habits?			
Any problems with passing urine, leakage, or trouble starting your stream?			
Any problems with sexual function?			
Do you have any other symptoms or health concerns, which have not been mentioned on this form? **(please explain)**			

Physician Signature _____ Printed Name _____

Date _____ Time _____