Johns Hopkins Bayview Medical Center
Memory & Alzheimer's Treatment Center
Patient Questionnaire

Date: _____

PATIENTS: PLEASE COMPLETE THIS QUESTIONAIRE BEFORE YOU SEE THE PHYSICIAN.
The information your answers provide is essential for a thorough evaluation. The following pages include questions regarding your medical history, social history, and family. Please check the boxes or print your response in the given space as appropriate. If you do not know the answer to a given question, or if it is not applicable in your case, leave it blank. This information will be used to help the physician to learn about you and your medical history in order to make a diagnosis, decide about specific treatment and plan your general care. This information will be kept strictly confidential. Thank you.

Name and Address	**Contact Information**
Patient Name _____	Daytime Phone _____
Address _____	Home Phone _____
_____	Cell Phone _____
_____	Email _____

Demographic Information

Age ____ D.O.B. _____ Sex: ❑ Male ❑ Female
Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated ❑ Partnered

Lives with: _____ Highest education: _____
Organ Donor: ❑ Yes ❑ No Religion: _____

Advanced Directive: ❑ Yes ❑ No Type _____
If No, would you like information about completing an Advance Directive? ❑ Yes ❑ No

Do you have a Power of Attorney (POA) designated for you? ❑ Yes ❑ No **If yes**, please identify name of POA here _____ and relationship to patient _____ ***Please bring the POA papers to your initial evaluation appointment.***

Sources of Information

❑ Patient
❑ Informant: Name/relationship _____ Phone _____

Who referred you for this evaluation? Physician's Name: _____
Address _____
City _____ State _____ Zip code _____

Phone _____ Fax _____

What do you see as your main problem or concern? (Describe what and when it started, how it affects you and if any, treatment you have already tried for it)

_____

_____

Medical History: Name of Primary Medical Doctor: _____
Date the last time seen by this doctor? _____

The following is a list of possible medical illnesses. **Please place an "X" beside any that you have or have had in the past.**

Medical History

- ❑ Stroke
- ❑ Dementia
- ❑ Seizures or Epilepsy
- ❑ Hypertension (high blood pressure)
- ❑ Heart attack or coronary artery disease
- ❑ Heart Failure
- ❑ Irregular heart beat or Arrhythmia
- ❑ Hepatitis
- ❑ Thyroid disease
- ❑ Arthritis – osteoarthritis / Rheumatoid arthritis
- ❑ Peripheral Neuropathy
- ❑ Head Injury
- ❑ Diabetes
- ❑ High cholesterol
- ❑ Asthma or COPD or Emphysema
- ❑ Cancer
- ❑ Depression
- ❑ Anxiety
- ❑ Other _____

Surgical History _____

_____

OB/GYN History _____

_____

Review of Systems Summary (of boxes checked above, please describe below)

Problem/Diagnosis	Onset	Treating Provider	Comments

Past/Current Psychiatric History

Problem/Diagnosis	Symptoms	Onset	Treatment	Treating Provider	Comments

Hospital admissions: (Please describe, date, reason)

_____

_____

REVIEW OF SYSTEMS: Please circle & provide brief details for the symptoms listed below that apply to you now.

CONSTITUTIONAL SYMPTOMS
Fever
Night sweats
Fatigue
Weight gain
Weight loss

RESPIRATORY
Chronic cough
Coughing up blood
Wheezing
Shortness of Breath

CARDIOVASCULAR
Chest Pain
Irregular heart beat
Shortness of breath
Palpitations
Swelling (feet, ankles, hands)

GASTROINTESTINAL
Loss of appetite
Diarrhea
Constipation
Blood in stools
Rectal bleeding
Nausea
Vomiting
Reflux
Abdominal pain

GENITOURINARY
Urinary urgency
Frequent urination
Blood in urine
Painful urination
Incontinence
Vaginal discharge
Irregular menses
Painful menses
Inability to achieve erection
Inability to perform intercourse

EYES
Blurred vision
Double vision
Eye injury
Discharge from eyes

EAR/ NOSE/ THROAT
Hearing loss
Ringing in ears
Dizziness
Vertigo
Discharge from ears/nose
Nose bleeds
Bleeding gums
Sinusitis
Lack of taste or smell

INTEGUMENTARY
Skin rash
Itching
Change in skin color
Change in hair or nails
Breast pain
Breast lump
Breast discharge

MUSCULOSKELETAL
Joint pain
Joint stiffness
Joint swelling
Back pain
Neck pain
Cold extremities

ENDOCRINE
Heat or cold intolerance
Excessive thirst or urination
Change in hat/glove size

HEMATAOLOGIC/ LYMPAHTIC
Enlarged nodes or glands
Bleeding tendency
Anemia
Phlebitis

PSYCHIATRIC
Anxiety
Low mood
Fear
Panic Attacks
Sadness
Visual hallucination
Auditory hallucination

NEUROLOGICAL
Headache
Weakness
Stiffness
Numbness
Seizures or convulsions
Tingling
Difficulty chewing
Choking
Difficulty walking
Falls
Tremors
Memory Loss
Confusion
Trouble concentrating
Insomnia/ Trouble sleeping
Snoring

NOTES:

ALLERGIES: Please list all drugs that you are allergic to and **describe** what the allergic reaction was:

MEDICATIONS: ON THE MEDICATION LIST ENCLOSED…..Please list all medications that you are currently taking (including **over the counter** medications, **vitamins,** and **herbal** supplements) Please list dosage and when medication is taken.

For clinic use only

Date: _____

Reviewed by _____

Print Name _____