JOHNS HOPKINS
MEDICINE
THE JOHNS HOPKINS HOSPITAL

Patient ID will go here.

Welcome!

Johns Hopkins University
The Lupus Center
New Patient Information

Welcome to the Johns Hopkins University Lupus Center. You have received an outpatient appointment to be seen by The Lupus Center faculty. You may first be seen by a Rheumatology Post-doctoral "Fellow" a board certified internist, or a physician's assistant.

PREPARING FOR YOUR VISIT

- Gather ALL records of your illness from the time of diagnosis, then **fax them BEFORE** your appointment to **410-614-0498.** ***It is essential that Drs. Petri and/or Stojan review ALL the records of your illness from the time of diagnosis.***
- Fill out this form completely BEFORE your visit to the center. Please ensure that the information is up to date at the time of your review. Please fax this completed form to 410-614-0498 prior to your visit. You may also email it to lupuscenter@jhmi.edu before the appointment.
- Please print clearly and answer each question fully. This will maximize the time available for discussion with the physicians who see you at the Lupus Center.

PATIENT INFORMATION

__/__/__ Date of Visit | Age | __/__/__ Date of Birth

Your Last Name | First Name | Middle Name

PRESENT CONDITION

So far, what diagnosis, if any, have you been given by your doctor(s)?

Why have you come to the Johns Hopkins Lupus Center?

What do you see as your main problems/complaints?

How long have you had this problem? _____ weeks OR _____ months OR _____years

PHYSICIAN INFORMATION

Please provide information on the doctor(s) involved in your care, including the doctor who referred you to us.

Primary Care Physician/Internist Patient for how long?

Address

City State ZIP Code

( ) Doctor's Phone Number ( ) Doctor's Fax Number

Referring Doctor Patient for how long?

Address

City State ZIP Code

( ) Doctor's Phone Number ( ) Doctor's Fax Number

JHOC RHEUM NPI (Rev 11/19)

Don't Forget

- Fax your records to 410-614-0498 before your appointment.
- Fill out this form completely, printing clearly.
- Please fax completed form to 410-614-0498 or email to lupuscenter@jhmi.edu.

PHYSICIAN INFORMATION continued

Rheumatologist Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

Neurologist Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

Dermatologist Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

Gastroenterologist Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

Other Doctor Name/Specialty Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

Other Doctor Name/Specialty Patient for how long?

Address

City State ZIP Code

( ) ( )

Doctor's Phone Number Doctor's Fax Number

PERSONAL AND SOCIAL HISTORY Please answer each question and give details when prompted.

Choose one: I am: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed/er

Do you have children? ☐ No ☐ Yes If yes, how many sons?____ How many daughters?____

Do your children have any illnesses? ☐ No ☐ Yes

If yes, please explain _____

_____

What do you do for work/What is your job (e.g., homemaker, shop-owner, etc.)?_____

Are you on disability? ☐ No ☐ Yes If yes, since when? _____ For what condition? _____

Do you drink alcohol? ☐ No ☐ Yes

If no, did you drink in the past? ☐ No ☐ Yes If yes, when did you stop?_____ Why?_____

If yes, how much do you drink in an average week (beers/glasses of wine/shots)? _____ drinks

Do you smoke? ☐ No ☐ Yes

If no, did you smoke in the past? ☐ No ☐ Yes If yes, how much per day? _____

Year quit_____ Why? _____

If yes, how many, on average, cigarettes do you smoke each day?_____

What is your height? _____feet _____ inches

What is your ethnicity (race)? _____

What is the ethnicity of your grandparents? Maternal Grandmother _____ Maternal Grandfather _____

Paternal Grandmother_____ Paternal Grandfather _____

SURGICAL HISTORY

Have you ever had surgery (including childhood)? ☐ No ☐ Yes If yes, list type and approximate year.

Type of Surgery	Year	Type of Surgery	Year

HOSPITALIZATION HISTORY

Have you ever been hospitalized? ☐ No ☐ Yes If yes, list reason and approximate year.

Reason for Hospitalization	Year	Reason for Hospitalization	Year

MEDICAL HISTORY

Have you ever had tuberculosis (TB)? ☐ No ☐ Yes

Have you ever had high blood pressure? ☐ No ☐ Yes

Have you ever had high cholesterol? ☐ No ☐ Yes

Have you ever had hepatitis? ☐ No ☐ Yes

Have you ever been diagnosed with gout? ☐ No ☐ Yes

Have you ever had a blood transfusion? ☐ No ☐ Yes If yes, what year(s) approximately _____

Have you ever been diagnosed with depression? ☐ No ☐ Yes

Have you ever been diagnosed with fibromyalgia? ☐ No ☐ Yes

Have you ever been diagnosed with irritable bowel syndrome? ☐ No ☐ Yes

Have you ever been diagnosed with migraines? ☐ No ☐ Yes

Have you ever been diagnosed with osteoporosis? ☐ No ☐ Yes

Have you ever been diagnosed with either Crohn's disease or ulcerative colitis (i.e., inflammatory bowel disease? ☐ No ☐ Yes

Have you ever been diagnosed with psoriasis (scaly skin condition)? ☐ No ☐ Yes

Have you ever had a DEXA scan (looking for osteoporosis)? ☐ No ☐ Yes If yes, when _____

Did you have osteopenia? ☐ No ☐ Yes

Did you have osteoporosis? ☐ No ☐ Yes

Women Only

Have you taken birth control pills? ☐ No ☐ Yes

Have you reached menopause? ☐ No ☐ Yes

If no, date of your last menstrual period (answer at time of visit) _____/_____/_____

If no, do you plan on having children in the future? ☐ No ☐ Yes

If yes, what year did your periods end? _____

If yes, are you on hormone replacement therapy? ☐ No ☐ Yes If no, list reason (history of breast cancer, thrombosis/clots, just decided not to)_____

FAMILY HISTORY (Referring to mother/father/brothers/sister/children)

Father

Is your father alive? ☐ Yes
☐ No Age at death_____
Cause_____

Mother

Is your mother alive? ☐ Yes
☐ No Age at death _____
Cause _____

Brothers

Do you have brothers? ☐ No
☐ Yes Are they all alive? ☐ Yes ☐ No
Cause(s) of death_____
_____
_____
_____

Sisters

Do you have sisters? ☐ No
☐ Yes Are they all alive? ☐ Yes ☐ No
Cause(s) of death_____
_____
_____
_____

Do any of your family members have arthritis? ☐ No ☐ Yes If yes, what kind _____

Do any members of your *close* family (mother, father, brothers and/or sisters) have any of the following diagnoses?

Diabetes mellitus ☐ No ☐ Yes If yes, relationship(s) _____
If yes, are/were they on insulin? ☐ No ☐ Yes

Thyroid disorders (i.e., goiter, hypothyroidism or hyperthyroidism) ☐ No ☐ Yes

Rheumatoid arthritis ☐ No ☐ Yes

Osteoarthritis (i.e, "old-age" arthritis, "wear-and-tear" arthritis) ☐ No ☐ Yes

Lupus ☐ No ☐ Yes

High blood pressure (hypertension) ☐ No ☐ Yes

High cholesterol ☐ No ☐ Yes

Heart attacks ☐ No ☐ Yes If yes, relationship and at what age _____

Strokes ☐ No ☐ Yes If yes, relationship and at what age _____

Breast cancer ☐ No ☐ Yes If yes, relationship and at what age _____

REVIEW OF SYSTEMS

1. GENERAL HEALTH

a) Are you having fever (temperature greater than 100 degrees)? ☐ No ☐ Yes
b) Do you have night sweats? ☐ No ☐ Yes
c) Have you lost more than 5 pounds in the last 3 months? ☐ No ☐ Yes
d) Do you have problems sleeping? ☐ No ☐ Yes

2. SKIN

a) Have you had any serious skin rashes? ☐ No ☐ Yes
b) Do you get rashes from the sun? ☐ No ☐ Yes
c) Have you had bumps or lumps in your skin? ☐ No ☐ Yes
d) Have you had psoriasis? ☐ No ☐ Yes
e) Is your hair falling out? ☐ No ☐ Yes

3. EYES

a) Have you lost your vision at any time? ☐ No ☐ Yes
b) Have you had a painful eye (iritis, uveitis)? ☐ No ☐ Yes
c) Have you had a red eye (conjunctivitis)? ☐ No ☐ Yes
d) Are your eyes very dry or gritty? ☐ No ☐ Yes

4. EARS

a) Have you had a painful or swollen outer ear? ☐ No ☐ Yes
b) Have you had frequent ear infections (otitis)? ☐ No ☐ Yes

5. NOSE

a) Have you had discharge or bleeding from the nose frequently? ☐ No ☐ Yes

REVIEW OF SYSTEMS Continued

6. MOUTH

a) Do you have frequent canker or mouth ulcers? ☐ No ☐ Yes

b) Do you have difficulty swallowing a cracker without water? ☐ No ☐ Yes

c) Have you had a yeast (thrush, Candida) infection of the throat? ☐ No ☐ Yes

7. ENDOCRINE

a) Do you have swollen glands? ☐ No ☐ Yes

b) Do you have diabetes? ☐ No ☐ Yes

c) Do you have a thyroid problem? ☐ No ☐ Yes

8. CHEST

a) Have you had pleurisy (a sharp pain at the end of every deep breath)? ☐ No ☐ Yes

b) Have you had pneumonia? ☐ No ☐ Yes

c) Have you had fluid in your lungs? (water, effusion)? ☐ No ☐ Yes

d) Are you short of breath easily? ☐ No ☐ Yes

9. CARDIAC

a) Have you had any inflammation of the heart lining (Pericarditis)? ☐ No ☐ Yes

b) Have you had a heart attack? ☐ No ☐ Yes

10. GASTROINTESTINAL

a) Do you have difficulty with swallowing or regurgitation? ☐ No ☐ Yes

b) Have you ever had stomach ulcers? ☐ No ☐ Yes

c) Have you ever had prolonged diarrhea? ☐ No ☐ Yes

d) Have you had blood in your stools frequently? ☐ No ☐ Yes

e) Did you have "irritable bowel" with diarrhea and constipation? ☐ No ☐ Yes

11. RENAL

a) Have you ever had kidney failure? ☐ No ☐ Yes

b) Have you ever had blood in your urine? ☐ No ☐ Yes

c) Have you had a kidney stone? ☐ No ☐ Yes

12. GYN/GU

a) If a woman: Have you had any miscarriages? ☐ No ☐ Yes

b) If a man: Have you had urethritis (painful urination)? ☐ No ☐ Yes

c) If a man: Have you had problem with impotence? ☐ No ☐ Yes

13. EXTREMITIES

a) Have you had any swelling (edema)? ☐ No ☐ Yes

b) Have you ever had any blood clots (phlebitis)? ☐ No ☐ Yes

c) Do your fingers turn color in the cold? ☐ No ☐ Yes

14. NEUROLOGIC

a) Have you lost feeling anywhere on your body? ☐ No ☐ Yes

b) Do you have numbness or tingling in your hands? ☐ No ☐ Yes

c) Do you have severe headaches? ☐ No ☐ Yes

d) Have you developed weakness anywhere in your body? ☐ No ☐ Yes

Your healthcare is very important to us.

Thank you for choosing Johns Hopkins.

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Medication List

It is important that you fill this out COMPLETELY. If need be, find out from you doctors, the exact dose of any medicines you are taking. This list should include prescription medicines, over-the-counter medicines, vitamins, and supplements from any source. For example, the list should include aspirin, the contraceptive birth control pill, vitamins, minerals, herbal remedies, sports supplements, and any supplements (powders, tablets, drinks, etc.) from an alternative medicine source or a health shop.

Name of Local Pharmacy _____

City _____

Phone ( ) _____ Fax ( ) _____

Name of Mail Order Pharmacy _____

City _____

Phone ( ) _____ Fax ( ) _____

Medication Name	Dose (How much)	Frequency (How Often)
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		
12.		
13.		
14.		
15.		
16.		
17.		
18.		
19.		
20.		

DRUG ALLERGIES Please list any medicines you have had a reaction to

NAME OF MEDICINE	REACTION	NAME OF MEDICINE	REACTION	NAME OF MEDICINE	REACTION

Physician's Initials_____

It is very important for your health that you answer these questions as completely and accurately as you can. If you do not understand something, please ask us for help.
We want you to live a healthier life.