Additional History for Multiple Sclerosis Patients

This questionnaire was developed to compile information about all of the Multiple Sclerosis patients in our practice. This questionnaire is completely optional. All of your information will remain confidential. We may at some time, compile the statistics of everyone's information in future articles that could be published. In the event any of the data is used, your information will only be associated with a number, never your name or initials.

Name: _____ Age:_____ DOB:_____

Male _____ Female _____ Marital Status (Married, Single, Divorced):_____

Date and Age when first symptoms of MS occurred: _____

What were your first symptoms? _____

_____

_____

Date of first diagnosis with MS: _____ Age at first diagnosis: _____

Methods used to diagnose- check all that apply:

___MRI of Brain	Evidence of MS? Yes / No
___MRI of Cervical Spine	Evidence of MS? Yes / No
___MRI of Thoracic Spine	Evidence of MS? Yes / No
___Lumbar Puncture/Spinal Tap	Evidence of MS? Yes / No
___Visual Evoked Potentials	Evidence of MS? Yes / No
___Optical Coherence Tomography	Evidence of MS? Yes / No

Names of the healthcare providers that previously followed you: _____

_____

Were you first diagnosed with Relapsing Remitting Multiple Sclerosis? Yes / No

Do you know which category you would fit into now?

___Relapsing Remitting- intermittent exacerbations and improvements

___Secondary Progressive- intermittent exacerbations that lead to a gradual worsening

___Primary Progressive- gradual worsening without exacerbations or improvements

Of the following associated symptoms, please check those that you have experienced:

___ Fatigue	___ Bladder dysfunction	___ Slurred Speech
___ Numbness	___ Bowel dysfunction	___ Emotional changes
___ Tingling	___ Sexual dysfunction	___ Personality changes
___ Pain	___ Muscle spasms	___ Depression
___ Weakness	___ Blurry vision	___ Cognitive Problems
___ Tremors	___ Double vision	___ Memory Loss
___ Gait problems	___ Balance problems	Other: _____
___ Poor coordination	___ Dizziness	_____

If you have relapses/exacerbations, how often do they occur? _____

How many total relapses have you had? _____

When was your last relapse? _____

Have you ever been treated with:

_____ Oral Steroids (e.g. Prednisone)	Side effects? Yes / No
_____ IV Steroids (e.g. Solumedrol)	Side effects? Yes / No
_____ Corticotropins (e.g. ACTHar gel)	Side effects? Yes / No
_____ Plasma Exchange	Side effects? Yes / No
_____ IVIG	Side effects? Yes / No

Were these treatments effective in relieving your symptoms? Yes / No

Comments: _____

_____

Are you currently on a disease modifying therapy? Yes / No

Current disease modifying therapy: _____

Date started: _____

Past disease modifying therapies used:

Name of medication	Date Started	Date Ended	Reason for discontinuation

Are you currently taking Ampyra? Yes / No

Any prior use of chemotherapies? Yes / No

JC Virus Status:

____ JC virus positive by blood test

____ JC virus negative by blood test

____ Never tested / Do not know

Have you ever been involved in any MS related research? Yes / No

If yes, please describe: _____

_____

_____

_____

Which of the following best describes your level of physical activity?

___ I can ambulate more than ¼ mile without any difficulty or any assistive devices

___ I can ambulate more than ¼ mile with some level of assistance.

Assistance Used: _____

___ I can ambulate less than ¼ mile using a cane

___ I can ambulate less than ¼ mile using a walker

___ I can only ambulate short distance with a cane

___ I can only ambulate short distance with a walker

___ I cannot ambulate; I use a wheelchair for all mobility, independently

___ I cannot ambulate; I use a wheelchair for all mobility, but require assistance with mobility and transfers

Do you require assistance with activities of daily living? Yes / No

Comments: _____

_____

Are you able to perform gainful employment? Yes / No

Comments: _____

_____

Where were you born? _____

Where did you live for the first 15 years of your life? _____

_____

_____

_____

Biological Relatives Diagnosed with MS? Yes / No

How are they related to you? _____

Do you have other chronic conditions such as Arthritis, Lupus, or Fibromyalgia?

_____

_____

Were these diagnosed before or after MS? _____

Thank you very much for taking the time to provide this information. We appreciate your effort. By signing below, it only indicates that the information you have provided is accurate to the best of your knowledge and does not indicate any agreement or obligation.

Printed Name: _____

Signature: _____ **Date :** _____