SOUTH TAMPA MULTIPLE SCLEROSIS CENTER

PATIENT/CARE GIVER QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

Patient's Name: ______________________ Date: ______________________

Address: ______________________

____

City: ____________ State: ____________ Zip Code: ____________

Phone: ______________________ Marital Status: ______________________

Spouse/Care Giver Name: ______________________

Address: ______________________

Phone (H) ______________________ (W) ______________________

Occupation: ______________________

REFERRING PHYSICIAN

Name: ______________________ Phone: ______________________

Address: ______________________

____

PRIMARY PHYSICIAN

Name: ______________________ Phone: ______________________

Address: ______________________

____

How did you hear about the M.S. CENTER? ______________________

GENERAL HEALTH INFORMATION

Age: ____________ Weight: ____________ Height: ____________

Right Handed: ________ Left Handed: ________

Have you been diagnosed with M.S? Yes: ______ No: ______

When did you experience the first symptoms? Date: ____________

What were these symptoms? ____________

____

____

Have you ever had:

Optic Neuritis Yes ______ No ______

Transverse Myelitis Yes ______ No ______

Medication Allergies: ____________

____

Have you taken (now or previously) any of the following medications?

	NOW	PREVIOUSLY
IV Solumedrol (IV steroids)		
Prednisone (oral steroids)		
Avonax (Interferon Bla)		
Betaseron (Interferon Blb)		
Copaxone (Glatiramer Acetate)		
Methotrexate		
Imuran		
Monthly IV steroids		
Cyclosporine		
Mitoxantrone		
IV IgG		

CURRENT MEDICATION LIST

INSTRUCTIONS: PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING INCLUDING ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATION

MEDICATION	DOSAGE	REASON FOR TAKING

INSTRUCTIONS: PLEASE INDICATE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS

WHICH OF THESE SYMPTOMS ARE YOU EXPERIENCING NOW? CHECK ONE

Symptom					
Fatigue		___	Yes	___	No
Weakness	Upper Extremities	___	Yes	___	No
	Lower Extremities	___	Yes	___	No
Ambulation Problems		___	Yes	___	No
Memory problems		___	Yes	___	No
Thought process / Sequencing Difficulties		___	Yes	___	No
Headaches		___	Yes	___	No
Loss of Vision		___	Yes	___	No
Abnormal Sensation or Numbness		___	Yes	___	No
Tingling / Pins & Needles Sensation		___	Yes	___	No
Tremors		___	Yes	___	No
Pain & Burning Sensation		___	Yes	___	No
Doubled or Blurred Vision		___	Yes	___	No
Hearing Loss		___	Yes	___	No
Ringing in Ears		___	Yes	___	No
Vertigo / Dizziness		___	Yes	___	No
Weight	Loss	___	Yes	___	No
	Gain	___	Yes	___	No
Constipation		___	Yes	___	No
Loss of Bowel Control		___	Yes	___	No
Bladder Leakage		___	Yes	___	No
Bladder Urgency		___	Yes	___	No

Do you have any signs or symptoms of

Depression	______	Yes	______	No
Insomnia	______	Yes	______	No
Apathy or Loss of Interest	______	Yes	______	No
Suicidal Thoughts	______	Yes	______	No
Agitation / Anxiety	______	Yes	______	No
Visual Hallucinations	______	Yes	______	No

Which of the medical conditions do you presently have or have you had in the past?

Diabetes	____	Yes	____	No	High Blood Pressure	____	Yes	____	No
Thyroid Disease	____	Yes	____	No	Hearth Rhythm Problems	____	Yes	____	No
Tuberculosis	____	Yes	____	No	Heart Attack	____	Yes	____	No
Asthma	____	Yes	____	No	Stroke	____	Yes	____	No
Anemia	____	Yes	____	No	Epilepsy / Seizures	____	Yes	____	No
Cancer	____	Yes	____	No	Meningitis	____	Yes	____	No
Stomach Ulcers	____	Yes	____	No	Kidney Disease	____	Yes	____	No
Hepatitis	____	Yes	____	No	Arthritis	____	Yes	____	No
Liver Problems	____	Yes	____	No	Skin Disease or Problems	____	Yes	____	No
Gynecological Problems	____	Yes	____	No	____ N/A				
Prostate Problems	____	Yes	____	No	____ N/A				

FAMILY HISTORY

Is there a family history of any chronic disease or illness?

Stroke	____	Yes	____	No	Multiple Sclerosis	____	Yes	____	No
Heart Disease	____	Yes	____	No	Alzheimer's / Memory Disorder	____	Yes	____	No
Cancer	____	Yes	____	No	Headache / Migraine	____	Yes	____	No
Epilepsy	____	Yes	____	No	Other Conditions	____	Yes	____	No

If so, whom:

Relationship	____________________	Illness/Disease	____________________
Relationship	____________________	Illness/Disease	____________________
Relationship	____________________	Illness/Disease	____________________

SOCIAL HISTORY

Are your parents still living?

Mother ______ Yes ______ No Father ______ Yes ______ No

Do you have:

Brothers ______ Yes ______ No Sisters ______ Yes ______ No

Children ______ Yes ______ No

If any of the above are deceased, explain age and cause of death: ____________________________

____

____

Have you ever been exposed to toxic substances? ______ Yes ______ No
Do you smoke? ______ Yes ______ No
Do you drink alcohol? ______ Yes ______ No
How much do you drink? ____

Where were you born and raised until 18 years of age? ____________________________

____

Who lives at home with you? ____

Do you use:

cane _____ Yes _____ No wheelchair _____ Yes _____ No
walker _____ Yes _____ No drive a car _____ Yes _____ No

Are you currently working? _____ Yes _____ No

What type of work do you do? ____

What is your highest education level?
Grammar School Grade ____________________
High School Grade ____________________
College Graduate _____ Yes _____ No

Are you disabled? _____ Yes _____ No How long? ____________________

PRIOR SURGICAL HISTORY

Procedure: ______________________ Date: ______________

Procedure: ______________________ Date: ______________

Procedure: ______________________ Date: ______________

Procedure: ______________________ Date: ______________

Other Hospitalizations: ______________________

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HAVE YOU HAD ANY OF THE FOLLOWING?

MRI Brain ____ Yes ____ No

When? ______________ Where? ______________

MRI Spinal Cord ____ Yes ____ No

When? ______________ Where? ______________

Visual Evoked Response ____ Yes ____ No

When? ______________ Where? ______________

Brainstem Auditory Evoked Response ____ Yes ____ No

When? ______________ Where? ______________

Arm/Leg Evoked Responses (SSER) ____ Yes ____ No

When? ______________ Where? ______________

L.P./Spinal Tap ____ Yes ____ No

When? ______________ Where? ______________

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING WITH A CHECK-MARK IF IT PERTAINS TO YOU PRESENTLY:

General

- _______ Increased Fatigue
- _______ Weight Loss
- _______ Fever

Cardiac

- _______ Angina
- _______ Irregular Heartbeat
- _______ Heart Murmur
- _______ Heart Failure
- _______ Rheumatic Fever

Skin

- _______ Skin Cancer
- _______ Rash

Renal / Urinary

- _______ Blood in Urine
- _______ Kidney Stones

Head / Neck

- _______ Nose bleeds
- _______ Neck Injury
- _______ Hearing Loss
- _______ Ears Ringing
- _______ Loss of Smell
- _______ Hoarseness
- _______ Glaucoma
- _______ Macular degeneration
- _______ Cataracts

Gastrointestinal

- _______ Reflux
- _______ Hiatal Hernia
- _______ Blood in Stool
- _______ Diverticulitis
- _______ Change in Bowel Habits

Respiratory

- _______ Persistent Cough
- _______ Shortness of Breath
- _______ Pneumonia
- _______ Bronchitis

Gynecological

- _______ Irregular Menstrual Cycles
- _______ Abnormal Vaginal Bleeding
- _______ Contraceptive Use
- _______ Pregnancies

OTHER COMMENTS: ____

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