

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

<u>MEDICATION</u>	<u>DOSAGE</u>	<u>REASON FOR TAKING</u>

INSTRUCTIONS: PLEASE INDICATE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS

WHICH OF THESE SYMPTOMS ARE YOU EXPERIENCING NOW? CHECK ONE

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: _____

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: _____

