SOUTH TAMPA MULTIPLE SCLEROSIS CENTER

PATIENT/ CARE GIVER QUESTIONNAIRE

DEMOGRAPHIC INFORMATION

Patient Name: ____ Date: ____________________________

Address: ____

____

City: _____________________________ State: ______________ Zip Code______________________________

Best Phone Number: _______________________________________ Marital Status_____________________

Phone (H): ____________________________________ (W) ____

(Cell): ____

Spouse/ Care Giver Name: ____

Address: ____

Best number to reach Spouse or Care Giver: ____

REFERRING PHYSICIAN

Name: _______________________________________Phone: __________________ Fax: __________________

Address: ____

PRIMARY PHYSICIAN

Name: _______________________________________ Phone: __________________ Fax: ___________________

Address: ____

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/Spinal Cord MS involvement: Yes________________ No _________________

MEDICATION ALLERGIES: ____

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

	NOW	PREVIOUSLY
IV Solumedrol (IV steroids) for relapses		
Prednisone (Oral steroids)		
Avonex (Interferon B1a)		
Betaseron /Extavia (Interferon B1b)		
Rebif (Interferon B1a)		
Copaxone (glatiramer acetate)		
Methotrexate		
Monthly IV steroids		
Cyclosporine		
Mitoxantrone		
IV IgG		
Gilenya (fingolimod)		
Aubagio (teriflunomide)		
Tecfidera (dimethyl fumarate)		

Ampyra (dalfampridine)		

CURRENT MEDICATION LIST

INSTRUCTIONS: PLEASE LIST ALL MEDICATIONS THAT YOU ARE CURRENTLY TAKING, INCLUDING ALL PRESCRIPTION AND OVER-THE-COUNTER MEDICATIONS/SUPPLEMENTS.

MEDICATION	DOSAGE / FREQUENCY	REASON FOR TAKING

INSTRUCTIONS: PLEASE INDICATE THE APPROPRIATE ANSWER TO THE FOLLOWING QUESTIONS

WHICH OF THESE SYMPTOMS ARE YOU EXPERIENCING **NOW**? CHECK YES OR NO.

	YES	NO
Fatigue		
Weakness (upper extremities)		
Weakness (lower extremities)		
Ambulation problems		
Memory problems		
Thought process/sequencing difficulties		
Headaches		
Loss of vision		
Abnormal sensation or numbness		
Tingling/ pins & needles sensation		
Tremors		
Pain & burning sensation		
Doubled or Blurred vision		
Hearing loss		
Ringing in ears		
Vertigo/Dizziness		
Weight loss		
Weight gain		
Constipation		
Loss of Bowel Control		
Bladder leakage		
Bladder urgency		
Depression		
Insomnia		
Apathy or loss if interest		
Suicidal thoughts		
Agitation/anxiety		
Visual hallucinations		

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

	YES	NO		YES	NO
Diabetes			High Blood pressure		
Thyroid disease			Heart rhythm problems		
Tuberculosis			Heart attack		
Asthma			Stroke		
Anemia			Epilepsy/Seizures		
Cancer			Meningitis		
Stomach Ulcers			Kidney Disease		
Hepatitis			Arthritis		
Liver problems			Skin disease or problems		
Gynecological problems			Other		
Prostate problems			Other		

FAMILY HISTORY

Are you adopted? ________Yes ___________No Please answer if know biological parents history.

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

	YES	NO	Whom and age of death, if known?
Stroke			
Heart disease			
Cancer			
Epilepsy			
Multiple Sclerosis			
Alzheimer's/ Memory disorder			
Headache/Migraine			
Rheumatoid Arthritis			
Crohn's/Ulcerative Colitis			
Psoriasis			
Lupus			
Other Conditions			

SOCIAL HISTORY

Are your biological parents still living? Mother _______Yes _______No Father ______Yes ______No

How many: Brothers ______ Sisters ______

Children _______

If any of the above are diseased, explain age and cause of death: ____

____

SOCIAL HISTORY (CONT.)

Have you ever been exposed to toxic substances? ______Yes _______No

Do you smoke NOW? ______Yes _______No If you smoked in the past, when did you quit? __________

Do you drink alcohol? ______Yes _______No

If so, how much? ____

Where were you raised until you were 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

Leg/foot brace or device _______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

Post Graduate _________Yes ________No

Do you receive disability benefits? _______Yes ________No

Disability benefits started? (mo/year) ___________________________________

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? _________________________________

L.P./Spinal Tap ______Yes ______No

When? ___________________________ Where? _________________________________

REVIEW OF SYSTEMS

PLEASE CHECK ANY OF THE FOLLOWING WITH THE APPROPRIATE MARK, IF IT PERTAINS TO YOU:
O=NO, P=PAST, N=NOW

General

______Increased Fatigue
______Weight loss
______Fever
______ Sweats

Cardiac

_____Angina
_____Irregular heartbeat
_____Heart Murmur
_____Heart Failure/CHF
_____Heart Attack

Skin

______Skin Cancer
______Rash
______Shingles

Renal/Urinary

_____Blood in Urine
_____Kidney Stones
_____Kidney Failure

Head/Neck

____Nose Bleeds
____Neck Injury
____Hearing Loss
____Ears Ringing
____Swallowing difficulty
____Hoarseness
____Glaucoma
____Macular Degeneration
____ Cataracts
____Uveitis

Gastrointestinal

_____Reflux
_____Abdominal pain
_____Blood in Stool
_____Diverticulitis
_____Change in Bowel Habits
_____Constipation
_____Diarrhea

Respiratory

_____Persistent Cough
_____Shortness of Breath
_____Pneumonia
_____Bronchitis
_____Tuberculosis (TB)

Gynecological

____Irregular Menstrual Cycles
____Abnormal Vaginal Bleeding
____Contraceptive Use
____Pregnancies

Endocrine

_____Hypo-Thyroid
_____Hyper-thyroid
_____Grave's Disease
_____Diabetes-Insulin
_____Diabetes-non Insulin

OTHER COMMENTS: ____
____

Rev 8.1.14