



DEPARTMENT OF NEUROLOGY
DIVISION OF MULTIPLE SCLEROSIS

Appointments: (813)396-9478

<http://ms.health.usf.edu/>

MRN# _____

Provider: _____

Appt. Date: _____

Appt. Time: _____

Welcome to the University of South Florida Multiple Sclerosis Center!

The information regarding your appointment is listed above. For your convenience we have enclosed a neurology questionnaire and a map to the Carol and Frank Morsani Center for Advanced Healthcare.

Dr. Derrick Robertson, Dr. Janice Maldonado and Lise Casady, ARNP function as a team and you may see any of the providers while under our care.

Coming to your appointment prepared enables you and your provider to make best use of your time. A new patient should arrive 30 minutes prior to his/her scheduled appointment time in order to complete the registration process. Please remember to bring the following information with you to your appointment:

- Insurance card or policy
- The completed Neurology questionnaire (Attached)
- **MRI films or disc (These do not get sent from your doctor, you must obtain them from the MRI facility if they are not in your possession)**
- All other pertinent records and test results.
- Reports from pertinent hospitalizations or other neurologists
- Completed symptom questionnaire.

The above information is vital for the providers to provide quality care. Your provider may not be able to see you if you arrive for your appointment without these documents. We prefer to have these records in advance of your visit. Please have them sent to our office mailing address at:

**12901 Bruce B. Downs Blvd. MDC-55
Tampa, FL 33612**

Alternatively, you may fax them to:

**Heather Salsburg, LPN
813-905-9838**

If you carry an HMO insurance policy, you are responsible for contacting your primary care physician and obtaining a referral. We will be unable to see you without proper authorization.

If you are unable to keep your appointment, a 48-hour cancellation is appreciated.

Part of the USF mission is to teach the next generation of health care providers in an environment that fosters excellence in education, research, and compassionate patient care. Because we are an academic medical group, our faculty providers lead patient care teams that may include medical students, residents, fellows, and other health care providers. The providers you may encounter on your visit are as follows:

- **Medical Students:** Students training to become physicians through a four-year course of study for a medical degree at the USF College of Medicine.
- **Residents:** Physicians training for a certain specialty.
- **Fellows:** Physicians who have typically gone beyond residency training and are continuing their studies in a subspecialty area of their field.
- **Physician Assistants (PA) / Advanced Registered Nurse Practitioner (ARNP):** A PA or ARNP are trained and qualified through advanced training to assume some of the duties and responsibility formerly assumed only by a physician.

As a patient, you help us to educate tomorrow's health care professionals while gaining access to the latest knowledge and advances in medicine. We appreciate your cooperation within our teaching efforts.

* We adhere to the CDC opioid prescription guidelines and participate in a multidisciplinary approach to the management of chronic pain with the use of Physical Therapy, Psychology and Pain Management Physicians. Nonpharmacologic therapy and nonopioid pharmacologic therapy are preferred for chronic pain. If your previous neurologist prescribed these opioid medications for you, we will renew them only until you are established with a Pain Management provider. These types of medications are highly regulated and require special handling. Please speak with us about this if this applies to you.

Appointment Reminders:

As a service to our patients, we have an automated appointment reminder system to provide you with a reminder of your next scheduled appointment. Televox will text or call seven days AND three days in advance of your next appointment. When you receive your appointment reminder it is **very important** to either confirm or cancel your appointment. Once established, you will be asked to sign up for MyChart, our patient portal. You will receive text message reminders through this system.

Thank you very much for choosing the University of South Florida Multiple Sclerosis Center and we look forward to seeing you.

Helpful Information

- Please allow 48 hours on most prescription refills. *Don't wait until you are out of a medication to call us please.*
- Prior authorizations require 5 working days
- Disability forms/FMLA forms may require an office visit and/or a \$25 fee for completion. These may require up to 2 weeks for completion.

Sincerely,

Derrick Robertson, MD, Janice Maldonado, MD and Lise' Casady ARNP
University of South Florida
Department of Neurology

Date of Visit: ____/____/____

Multiple Sclerosis Clinic NEW PATIENT Visit Questionnaire

Patient NAME: _____

Patient DATE OF BIRTH: ____/____/____

Referring Physician Name: _____

Referring Physician Phone: (____) - ____ - ____; Fax: (____) - ____ - ____

Primary Care Physician Name: _____

Primary Care Physician Phone: (____) - ____ - ____; Fax: (____) - ____ - ____

Pharmacy Name: _____ (please circle one): Retail / Mail Order

Address: _____

Pharmacy Phone: (____) - ____ - ____; Fax: (____) - ____ - ____

1. What is the reason for your visit (please circle ALL that apply):
- a. Second opinion on diagnosis b. Second opinion on treatment c. Establish care

2. What was the approximate date of your first symptom? ____/____/____

3. Please describe your symptoms at time of diagnosis:

4. If you are on Disease-Modifying Therapy,
- a. (please circle): None, Avonex, Betaseron, Rebif, Copaxone, Glatopa, Tysabri, Extavia, Gilenya, Tecfidera, Aubagio, Plegridy, Lemtrada, Ocrevus, Rituxan, Zinbryta
- b. What percentage of the time are you taking the medication?: _____ %
- c. How long have you been on the current therapy?: _____
- d. Are you experiencing any side effects (if so, please describe): _____

5. List any medications you have used for management in MS:

(please include a. approximate date(s) of use and b. reason for discontinuation)

- | | | |
|---------------------------------------|-------------|---------------------------|
| <input type="checkbox"/> Avonex | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Betaseron | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Rebif | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Copaxone | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Aubagio | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Gilenya | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Tecfidera | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Tysabri | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Mitoxantrone | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Plegridy | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Ocrevus | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Rituxan | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Extavia | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Lemtrada | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Zinbryta | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Steroids | date: _____ | reason for stopping _____ |
| <input type="checkbox"/> Other _____ | date: _____ | reason for stopping _____ |

6. List any other medications you have used for symptomatic management of MS:

(please include a. approximate date(s) of use and b. reason for discontinuation)

7. What are the top three concerns you would like to address today?

1. _____
2. _____
3. _____

8. Would you be interested in participating in ongoing research in multiple sclerosis? Yes No

9. Please provide us with more information about your MS symptoms by answering the following questions:

Vision Questionnaire

- | | | | |
|---|-----|----|------------------------------------|
| Do you have difficulty seeing? | Yes | no | |
| - Blurry vision | Yes | no | |
| - Double vision | Yes | no | |
| - Wear glasses or contacts | Yes | no | |
| - Eye Pain | Yes | no | |
| - Loss of vision | Yes | no | |
| Do you wear corrective lenses? | Yes | no | |
| Do you see an eye doctor? | Yes | no | When was your last eye exam? _____ |
| Do you have problems with peripheral vision? | Yes | no | |
| Do you see black in an area of your vision? | Yes | no | |
| Do you have difficulty moving your eyes? | Yes | no | |
| Do your eyes ever feel like they are shaking? | Yes | no | |
| Have you ever had optic neuritis? | Yes | no | |
| Do you have pain when moving your eyes? | Yes | no | |
| Do colors ever look different to you? | Yes | no | |

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Brainstem Questionnaire

Do you have any numbness on your face?	Yes	No
Do you have any facial pain?	Yes	No
Do you have any weakness in your face?	Yes	No
Do you have hearing loss?	Yes	No
Do you have difficulty with speech?	Yes	No
Do you have difficulty swallowing foods?	Yes	No
Do you have difficulty swallowing liquids?	Yes	No

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Pyramidal Function Questionnaire

Do you have any weakness?	Yes	No
If yes, where?	L arm / R arm / L leg / R leg	
Do you have any spasms (tight muscles)?	Yes	No
If yes, where?	L arm / R arm / L leg / R leg	
Do you have muscle spasms in your neck or back?	Yes	No
Do you have spasms while walking?	Yes	No
Do you have fatigue during strenuous tasks?	Yes	No
Are you able to exercise?	Yes	No

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Cerebellar Functions Questionnaire

Do you have balance difficulty?	Yes	No
Are you able to sit without assistance?	Yes	No
Do you have shaking or tremors?	Yes	No
Are you able to stand with your eyes closed?	Yes	No
Are you clumsy?	Yes	No
Do you have unsteady walking?	Yes	No
Do you fall frequently?	Yes	No
Do you get vertigo or dizziness?	Yes	No

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Sensory Functions Questionnaire

Do you have any sensory problems? If yes, please circle below.	Yes	No
<input type="checkbox"/> Pain		L arm / R arm / L leg / R leg
<input type="checkbox"/> Numbness		L arm / R arm / L leg / R leg
<input type="checkbox"/> Tingling		L arm / R arm / L leg / R leg
<input type="checkbox"/> Itching		L arm / R arm / L leg / R leg
<input type="checkbox"/> Painful Cold		L arm / R arm / L leg / R leg
<input type="checkbox"/> Burning Sensation		L arm / R arm / L leg / R leg
<input type="checkbox"/> Shock-Like Sensation		L arm / R arm / L leg / R leg
<input type="checkbox"/> Increased Sense to Touch		L arm / R arm / L leg / R leg

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Bowel and Bladder Functions Questionnaire

Do you have difficulty emptying your bladder?	Yes	No
Do you have frequent urinary tract infections?	Yes	No
Do you self-catheterize?	Yes	No
Do you have urinary incontinence (lose control of urine)? If yes, more or less than once a week?	Yes More	No Less
Do you wear pads because of urinary incontinence?	Yes	No
Do you have full loss of bladder control?	Yes	No
Do you have constipation?	Yes	No
Do you need an enema or manual measures to evacuate bowels?	Yes	No
Do you have bowel incontinence (loss of control of stool)?	Yes	No
Do you wear pads because of bowel incontinence?	Yes	No
Have you seen a urologist?	Yes	No
Have you seen a gastrointestinal doctor?	Yes	No

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Sexual Dysfunction Questionnaire

Do you have any sexual dysfunction?	Yes	No
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Please further explain your symptoms if you answered “Yes” above, as well as any treatments you have tried.

Cerebral Functions Questionnaire

Do you suffer from anxiety and/or depression? Yes No

Do you have fatigue? Yes No

If yes, please check severity below

- Minimal; able to go about daily activities with minimal effect, occasional rest breaks needed
- Moderate; able to perform activities of daily living with lifestyle modifications and medications for symptoms management
- Severe; unable to perform most activities of daily living, and minimal exertion results in fatigue

Do you have difficulty with memory? Yes No

If yes, please check severity below

- Mild; need to take extra measures to maintain schedules and appointments
- Moderate; difficulty with multi-tasking, problem-solving, and short-term memory
- Severe; unable to manage finances, appointments or medications regimen
 - Have you had any formal cognitive testing? No Yes (*if yes, when and where?*)

Please further explain your symptoms to any questions you answered “Yes” above, as well as any treatments you have tried.

Mobility

Section A

How would you best describe your ability to ambulate (walk)? (check one)

- No restrictions when walking, without assistance (do not use a cane, crutch, or walker). I can walk several city blocks without having to take a break.
- I can walk without assistance (do not use a cane, crutch, or walker), but I can only walk one city block then have to take a break.
- I can walk without assistance (do not use a cane, crutch, or walker), but I can walk less than one city block.
- I must use an assistive device (cane, crutch) on ONE side but I can walk over a city block with my device.
- I must use an assistive device (cane, crutch) on ONE side and can walk only a short distance
- I must use an assistive device (cane, crutch, walker) on BOTH sides but I can walk over a city block with my device.
- I must use an assistive device (cane, crutch, walker) on BOTH sides and can walk only a short distance
- I am able to walk some but spend the majority of the time in a wheelchair
- I am not able to walk and use a wheelchair at all times

Section B

Do you use a wheelchair? Yes No
If no, you may skip the remainder of the questions
Can you take a few steps with assistance? Yes No
Are you able to wheel yourself? Yes No
Are you able to transfer from your wheelchair? Yes No

Please provide any additional information.

OverHeating: No Yes (if yes, please elaborate) _____

MEDICAL HISTORY: Any recent **vaccinations?**: No Yes; _____

List any **medical problems** you are *currently* being treated for: _____

List any significant **medical problems** you treated for *in the past*: _____

SURGICAL HISTORY: _____

FAMILY HISTORY: (check ALL that apply)

Mother: Heart Disease; Diabetes; Cancer; Multiple Sclerosis; Other _____

Father: Heart Disease; Diabetes; Cancer; Multiple Sclerosis; Other _____

Sibling(s): Heart Disease; Diabetes; Cancer; Multiple Sclerosis; Other _____

Grandparent(s): Heart Disease; Diabetes; Cancer; Multiple Sclerosis; Other _____

SOCIAL HISTORY:

Ethnicity: _____

Marital status: Single / Married / Divorced; With / Without Children

Employment status: Employed (please elaborate): _____ / Unemployed On disability

Alcohol: no, occasional, frequent; type/amount: _____

Tobacco: no yes; _____ packs per day x _____ year(s); quit: ___ / ___ / _____

Recreational drugs: no yes; _____

FOR OFFICE USE ONLY:

PHYSICAL EXAMINATION

GENERAL: N ABN

COGNITIVE FUNCTION: N ABN

CN II-XII: N ABN;

II: V:
III, IV and VI: VII:

VIII: XI:
IX, X: XII:

MOTOR/STRENGTH: N ABN;

Bulk/Atrophy Tone Fasciculation.

RUE: Sh Abduction []; Sh Adduction []; Elbow Flexion []; Elbow Extension [];
 Wrist Extension []; Wrist Flexion []; Finger Flexion []; Finger Abduction [];

LUE: Sh Abduction []; Sh Adduction []; Elbow Flexion []; Elbow Extension [];
 Wrist Extension []; Wrist Flexion []; Finger Flexion []; Finger Abduction [];

RLE: Hip Flexion []; Knee extension []; Ankle DorsiFlexion []; Ankle PlantarFlexion []

LLE: Hip Flexion []; Knee extension []; Ankle DorsiFlexion []; Ankle PlantarFlexion []

SENSATION: N ABN; LT S/D Prop. Vib, Temp.

REFLEXES: N ABN;

R: Biceps: [] Triceps: [] Brachioradialis: [] Knee: [] Ankle: [] Clonus: []

L: Biceps: [] Triceps: [] Brachioradialis: [] Knee: [] Ankle: [] Clonus: []

UPPER MOTOR NEURON SIGNS: N ABN; Babinski

CEREBELLAR FUNCTION: N ABN; FTN HTS RAM

STATION AND GAIT: Unable to assess N ABN; Casual Tandem H/T Romberg

ASSESSMENT AND PLAN: