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, Tysabri, Gilenya, Tecfidera, Aubagio, Plegridy, Lemtrada
   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)

☐ Avonex	date:___________	reason for stopping______________________
☐ Betaseron	date:___________	reason for stopping______________________
☐ Rebif	date:___________	reason for stopping______________________
☐ Copaxone	date:___________	reason for stopping______________________
☐ Aubagio	date:___________	reason for stopping______________________
☐ Gilenya	date:___________	reason for stopping______________________
☐ Tecfidera	date:___________	reason for stopping______________________
☐ Tysabri	date:___________	reason for stopping______________________
☐ Mitoxantrone	date:___________	reason for stopping______________________
☐ Steroids	date:___________	reason for stopping______________________
☐ 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)
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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.

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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.

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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.

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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.

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Sensory Functions Questionnaire

Do you have any sensory problems?	Yes	No

If yes, please circle below.

□ Pain	L arm / R arm / L leg / R leg
□ Numbness	L arm / R arm / L leg / R leg
□ Tingling	L arm / R arm / L leg / R leg
□ Itching	L arm / R arm / L leg / R leg
□ Painful Cold	L arm / R arm / L leg / R leg
□ Burning Sensation	L arm / R arm / L leg / R leg
□ Shock-Like Sensation	L arm / R arm / L leg / R leg
□ 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.

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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)?	Yes	No
If yes, more or less than once a week?	More	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.

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Sexual Dysfunction Questionnaire

Do you have any sexual dysfunction? Yes No

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

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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.

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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

Are you in 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.

___

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___

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: VIII: XI:

III, IV and VI: VII: 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 Rhomberg

ASSESSMENT AND PLAN:

REVIEW OF SYSTEMS: *(please circle ALL that apply)*

CONSTITUTIONAL: Normal Fever Chills Weight loss Weight gain Fatigue

EYES: Normal Double vision Blurry vision Need for glasses Glaucoma Injury/Surgery

EARS/NOSE/THROAT: Normal Sinus infection Hearing loss Ringing in ears Sores Voice change Swelling

CARDIOVASCULAR: Normal Chest pain High blood pressure Palpitations Leg swelling

RESPIRATORY: Normal Shortness of breath Asthma Cough Spitting up blood Wheezing

GASTROINTESTINAL: Normal Loss of appetite Nausea Vomiting Pain Blood in stool Abnormal bowel movements

GENITOURINARY: Normal Frequent urination Painful urination Incontinence Infections Irregular menses

SKELETAL: Normal Joint pain or stiffness Weakness Injury or surgery Swelling Spasm

SKIN: Normal Rashes Ulcers Nail change

BREAST: Normal Breast pain Breast lump Breast discharge

NEUROLOGICAL: Normal Headaches Stroke or TIA Dizziness Seizure Loss of balance Tremors

PSYCHOLOGICAL: Normal Memory loss Depression Insomnia Nervousness

ENDOCRINE: Normal Diabetes Thyroid problem Excessive thirst Excessive urination

HEMATOLOGIC: Normal Bleeding Bruising tendency Transfusion

Patient Name: ____ Date of Visit: _____/_____/_____

Physician Signature: _______________________________________ Date of Visit: _____/_____/_____