Initial Visit Patient Information

To Be Filled Out Before Appointment

Vital Signs **(to be filled out by staff)**

Sitting BP: _____ mmHg
manual/automated (circle one)
Sitting Pulse: _____ bpm
O^2: _____ b/min
Temperature: _____ ◦F
Weight: _____ lbs
actual or stated (circle one)
25-Foot walk: sec

Date:_____

Patient Name: _____

Date of Birth: _____

Information provided by: _____

Relationship to patient:_____

Reason for Clinic Visit: (please check at least one)

- ☐ I have been diagnosed with MS and seek continued care (diagnosis date: _____)
- ☐ I have not been diagnosed with MS, but may have it
- ☐ I seek a second opinion about diagnosis/therapy
- ☐ I am interested in clinical trials and would like more information

Date of FIRST symptom (s): _____

What symptom (s) did you experience at that time? _____

Duration of symptoms: _____(hours/days/weeks/months/years).

Treatment?_____

List major new symptom events that happened next:	Approx. Dates	Steroids Given?

Diagnostic Test Type	Where Done?	Date of Most Recent Study
Brain MRI		
Spine MRI		
Spinal Tap		
Evoked Potentials		
Nerve Conduction Study		

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Original – Medical Record

MR

Name_____DOB_____ Date _____

MS Disease Modifying Therapies: If you have been treated in the past or are currently on therapy (including chemotherapy):

Name of Drug	Dates (Years) on therapy	Reason Discontinued

Medical History: Do you now or have you in the past been diagnosed with any of the following:

□ Cancer	□ Rheumatoid Arthritis	□ Asthma or COPD	□ Mononucleosis
□ Diabetes	□ High blood pressure	□ Stomach ulcer or bleed	□ Hepatitis
□ Thyroid Disorder	□ Heart attack	□ Kidney stones	□ Tuberculosis
□ Lupus	□ Stroke	□ Kidney disease	□ HIV
□ Crohn's Disease	□ Blood clotting problem	□ Liver disease	□ Concussion
□ Sarcoidosis	□ Multiple miscarriages	□ High cholesterol	□ Seizures
□ Sjogrens	□ Pregnancy	□ Depression/Anxiety	□ Migraine

Other (not listed):_____

Tobacco Product use:

Cigarettes Never/Former/Current (___ packs per day)

Cigars/Chew Never/Former/Current

Alcohol use: Never/Rare/Occasional
(number of drinks:___ per day:____ per week)

Recreational drug use: Never/Former/Current

What type of exercise do you do? _____

How often do you exercise? _____

How long can you exercise before you must stop? _____

Surgical History: List the type and dates of all past surgeries:

_____

_____

_____

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Name_____ **DOB**_____ **Date** _____

FAMILY HEALTH REVIEW: Please check all that apply and list family relationship to you:

	Condition/Disease	Relationship To You
	Multiple Sclerosis	
	Lupus	
	Crohns Disease	
	Thyroid Disease	
	Rheumatoid Arthritis	
	Juvenile Diabetes	
	Adult Onset Diabetes	
	Migraine	
	Seizures/Epilepsy	
	Bipolar Disorder	
	Depression	
	Alcoholism	
	Cancer	
	Other	

OTHER RELATED QUESTIONS:

Marital Status (Circle)	Married Single Divorced Widowed
Number Of Children And Ages	
Born/Raised Through Teens Where?	
Number Of Years Of Education	
Occupation	
Retirement Date	
Receiving Disability Insurance	Private SSDI
Home Set-Up	Multi-Level Single-Level Stairs: None Indoors Outdoors Safety Equipment:
Emotional Support Sources	

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Name_____ **DOB**_____ **Date** _____

List drug allergies: **Type of allergic symptoms:**

_____

_____

Your current list of medications: Indicate number of pills and time of day taken:

Medication Name and Strength	Morning	Noon	Afternoon	Evening	Bedtime

Pharmacy Name: _____

Pharmacy Telephone: _____ **/Fax:** _____

Refill amount requested (circle): 1 month supply / 3 month supply.

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Review of Symptoms

Please place an "x" next to current or recently experienced symptoms:

Constitutional Symptoms
- ☐ Uneplained Fevers
- ☐ Unexplained weight loss
- ☐ Drenching night sweats
- ☐ Poor quality of sleep

Eye
- ☐ Discharge
- ☐ Pain with eye globe movement
- ☐ Excessive dryness/tearing problems
- ☐ Cataract
- ☐ Lazy eye
- ☐ Bleached out color perception
- ☐ Grey areas or black holes in vision

Ear/nose/throat
- ☐ Hearing Loss
- ☐ Ear fullness or pain
- ☐ Ringing or buzzing in ears
- ☐ Sinus problems
- ☐ Sores on tongue/gums
- ☐ Problem with teeth
- ☐ Hoarseness
- ☐ Trouble swallowing

Cardiovascular
- ☐ Chest pain/discomfort
- ☐ Palpitations or irregular heart beat
- ☐ Shortness of breath w/exertion
- ☐ Shortness of breath lying flat

Respiratory
- ☐ Cough
- ☐ Shortness of breath/wheezing

Gastrointestinal
- ☐ Frequent nausea or vomiting
- ☐ Heartburn
- ☐ Stomach Pain
- ☐ Dark/Tarry looking stool
- ☐ Bright red blood in stool
- ☐ Constipation
- ☐ Frequent loose stools or diarrhea
- ☐ Bowel incontinence

Genitourinary
- ☐ Blood in urine
- ☐ Pain with urination
- ☐ Abnormal menstruation
- ☐ Breast lump or discharge
- ☐ Frequent awakenings due to bladder
- ☐ Bladder urgency and frequency with incontinence
- ☐ Bladder urgency and frequency without incontinence

Musculoskeletal
- ☐ Joint pain
- ☐ Joint swelling or redness
- ☐ Tender muscles
- ☐ Back or neck pain

Skin
- ☐ Skin Cancer
- ☐ Rash
- ☐ Injection site lumps
- ☐ Injection site pain/red

Neurological
- ☐ Seizures
- ☐ Loss of consciousness
- ☐ Dizziness/light headed
- ☐ Dizziness/Vertigo
- ☐ Headaches

Psychiatric
- ☐ Racing thoughts/Anxiety
- ☐ Poor mood/Depression
- ☐ Suicidal thoughts

Hematologic/Lymphatic
- ☐ Easy bruising/bleeding
- ☐ Enlarged lymph glands

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