

**Mercy MS Center
New Patient Information**

Last Name: _____ First Name: _____ DOB: _____

MULTIPLE SCLEROSIS HISTORY

Reason for clinic visit:

- I have been diagnosed with MS or NMO (Date diagnosed _____)
 I have not been diagnosed with MS, but may have it

When did you have your FIRST symptom? _____

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

Please list symptoms that happened next:

Approx. Date

	Approx. Date

Have you had attacks of symptoms that then go away (exacerbations and remissions)?

- Yes, No, Don't know

If yes, when was your most recent exacerbation? _____

If yes, have you had attacks that were treated with steroids? Yes, No

Do you have symptoms (for example, trouble walking or fatigue) which have not gone away for a year or more?

- Yes, No,

(For Office Use)

BP

HR

Resp

Weight

Name Label

Reviewed by _____

Date _____

Medical Tests:

MRI brain

Most recent date: _____ Where was it done? _____

What was result? _____

MRI spine

Most recent date: _____ Where was it done? _____

What was result? _____

Spinal Tap

Most recent date: _____ Where was it done? _____

What was result? _____

Other tests (Blood tests, evoked potential studies, EMG).

SYMPTOMS

Motor (Muscle) Symptoms

How far can you walk without resting?

- cannot take steps at all
- 5 steps or less
- 1 block or less
- less than a mile
- more than a mile

If you had falls due to MS, how many times did you fall in the past year? _____

Can you run? Yes No

Can you climb stairs? Yes No

	Now	In the past
Tremor of hands/arms	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty writing	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty handling eating utensils	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty dressing	<input type="checkbox"/>	<input type="checkbox"/>
Stiffness of legs walking	<input type="checkbox"/>	<input type="checkbox"/>
Jerks / spasms	<input type="checkbox"/>	<input type="checkbox"/>
Arms	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>
Muscle cramps	<input type="checkbox"/>	<input type="checkbox"/>

Sensory Symptoms

	Now	In the past
Numbness/Tingling		
Arms	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>
Face	<input type="checkbox"/>	<input type="checkbox"/>
Other body area	<input type="checkbox"/>	<input type="checkbox"/>
Where? _____		
Electric feeling in spine with bending neck	<input type="checkbox"/>	<input type="checkbox"/>

Pain

	Now	In the past
Pain		
Arms	<input type="checkbox"/>	<input type="checkbox"/>
Legs	<input type="checkbox"/>	<input type="checkbox"/>
Face	<input type="checkbox"/>	<input type="checkbox"/>
Other body area	<input type="checkbox"/>	<input type="checkbox"/>
Where? _____		

Your Name _____

Vision

	Now	In the past
Loss in 1 eye	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>
Abnormal color vision	<input type="checkbox"/>	<input type="checkbox"/>
Blind spots	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain	<input type="checkbox"/>	<input type="checkbox"/>

Bowel Symptoms

	Now	In the past
Urgency (can't wait)	<input type="checkbox"/>	<input type="checkbox"/>
Constipation	<input type="checkbox"/>	<input type="checkbox"/>
Bowel accidents	<input type="checkbox"/>	<input type="checkbox"/>

Bladder Symptoms

	Now	In the past
Urgency (can't wait)	<input type="checkbox"/>	<input type="checkbox"/>
Bladder accidents	<input type="checkbox"/>	<input type="checkbox"/>
Frequency (incl. night)	<input type="checkbox"/>	<input type="checkbox"/>
Hesitancy (can't go)	<input type="checkbox"/>	<input type="checkbox"/>
Bladder infections	<input type="checkbox"/>	<input type="checkbox"/>

Sleep Problems

	Now	In the past
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Snoring	<input type="checkbox"/>	<input type="checkbox"/>
Nightmares	<input type="checkbox"/>	<input type="checkbox"/>
Daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Restless leg syndrome	<input type="checkbox"/>	<input type="checkbox"/>

Other Symptoms

	Now	In the past
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>
Excessive sleepiness	<input type="checkbox"/>	<input type="checkbox"/>
Memory/cognitive issues	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Sexual problems	<input type="checkbox"/>	<input type="checkbox"/>
Heat worsens symptoms	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>
Other (specify) _____	<input type="checkbox"/>	<input type="checkbox"/>

Adaptive Equipment

	Now	In the past
Cane/crutch	<input type="checkbox"/>	<input type="checkbox"/>
Walker used in house	<input type="checkbox"/>	<input type="checkbox"/>
Walker only outside	<input type="checkbox"/>	<input type="checkbox"/>
Ankle foot orthosis	<input type="checkbox"/>	<input type="checkbox"/>
Manual Wheelchair	<input type="checkbox"/>	<input type="checkbox"/>
Power chair/scooter	<input type="checkbox"/>	<input type="checkbox"/>
Urinary catheter	<input type="checkbox"/>	<input type="checkbox"/>

Previous Treatments

What "MS Drugs" do you currently take or have you taken in the past:

_____ Approximate dates: Start _____ Ending _____
 _____ Approximate dates: Start _____ Ending _____
 _____ Approximate dates: Start _____ Ending _____

Have you ever participated in a clinical research trial? Yes No

Please tell us about the trial: _____

Your Name _____

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

	Now	Ever		Now	Ever
Constitutional symptoms			Genitourinary		
Unexplained fevers			Blood in urine		
Unexplained weight loss			Pain on urination		
Eye			Musculoskeletal		
Glaucoma			Joint pain		
Cataract			Back or neck pain		
Dry eyes			Arthritis		
Serious visual disorder			Fibromyalgia		
Ear/Nose/Mouth/Throat			Skin/breast		
Hearing loss			Skin rash		
Ringing in ears			Psoriasis		
Hoarseness			Breast lumps		
Voice change			Breast discharge		
Trouble swallowing			Neurological		
Dry mouth			Seizure		
Cardiovascular			Stroke		
Heart attack			Headaches		
Coronary bypass surgery			Head/brain injury		
High blood pressure			Psychiatric		
High cholesterol			Anxiety		
Atrial fibrillation			Bipolar disease		
Respiratory			Suicidal attempt(s)		
Cough			Hematological/Lymphatic		
Shortness of breath			Problems with blood clotting		
Asthma			Anemia		
Endocrine			Enlarged lymph nodes		
Diabetes			Leukemia / Lymphoma		
Thyroid disorder			ALLERGIES		
Osteoporosis			Iodine (shellfish)		
Gastrointestinal			Tape		
Liver problems			Latex		
Ulcers			Foods (specify):		
Stomach pain			Environmental (specify):		
Crohn's or ulcerative colitis			Medications (specify drug and reaction)		
Eating disorder					
Cancer					
Type of cancer and year					

Your Name _____

Primary doctor: Name _____ City _____

List other medical problems:

List previous surgeries:

HABITS:

Do you exercise? If so, what type? _____

Smoker: Never Previously Current _____ packs/day for _____ years
Alcohol: Never Previously Daily Several a week Less than once a week

“Recreational” drug use:

Never Previously

FAMILY HISTORY

	List Medical Illnesses
Father	Living <input type="checkbox"/> Yes <input type="checkbox"/> No
Mother	Living <input type="checkbox"/> Yes <input type="checkbox"/> No
Brother/Sister	Number ()
Children	Number ()

SOCIAL HISTORY

Marital status: Married Single Divorced Widowed

Occupation: Employed outside home Homemaker Retired Student

Unemployed/Between Jobs Disabled

If you are receiving disability, since what year? _____

Military Service: None Yes What branch and when? _____

Have you been abused? No Yes

Your Name _____

CURRENT MEDICATIONS

Medications: Include Prescription, Over the counter, complementary/alternative	Mg or IU in each pill	Taken how many times a day

What local pharmacy do you prefer? _____

What mail-in pharmacy do you use? _____

Who is your primary physician? _____

Please list other physicians who you would like to receive a copy of our reports?

Your Name _____