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

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	☐	☐
Difficulty writing	☐	☐
Difficulty handling eating utensils	☐	☐
Difficulty dressing	☐	☐
Stiffness of legs walking	☐	☐
Jerks / spasms	☐	☐
Arms	☐	☐
Legs	☐	☐
Muscle cramps	☐	☐

Sensory Symptoms

	Now	In the past
Numbness/Tingling		
Arms	☐	☐
Legs	☐	☐
Face	☐	☐
Other body area	☐	☐
Where?_____		
Electric feeling in spine with bending neck	☐	☐

Pain

	Now	In the past
Pain		
Arms	☐	☐
Legs	☐	☐
Face	☐	☐
Other body area	☐	☐
Where?_____		

Vision

	Now	In the past
Loss in 1 eye	☐	☐
Double vision	☐	☐
Abnormal color vision	☐	☐
Blind spots	☐	☐
Eye pain	☐	☐

Bowel Symptoms

	Now	In the past
Urgency (can't wait)	☐	☐
Constipation	☐	☐
Bowel accidents	☐	☐

Bladder Symptoms

	Now	In the past
Urgency (can't wait)	☐	☐
Bladder accidents	☐	☐
Frequency (incl. night)	☐	☐
Hesitancy (can't go)	☐	☐
Bladder infections	☐	☐

Sleep Problems

	Now	In the past
Insomnia	☐	☐
Snoring	☐	☐
Nightmares	☐	☐
Daytime sleepiness	☐	☐
Restless leg syndrome	☐	☐

Other Symptoms

	Now	In the past
Fatigue	☐	☐
Insomnia	☐	☐
Excessive sleepiness	☐	☐
Memory/cognitive issues	☐	☐
Depression	☐	☐
Dizziness	☐	☐
Sexual problems	☐	☐
Heat worsens symptoms	☐	☐
Other (specify)_____	☐	☐
Other (specify)_____	☐	☐

Adaptive Equipment

	Now	In the past
Cane/crutch	☐	☐
Walker used in house	☐	☐
Walker only outside	☐	☐
Ankle foot orthosis	☐	☐
Manual Wheelchair	☐	☐
Power chair/scooter	☐	☐
Urinary catheter	☐	☐

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: _____

PAST MEDICAL HISTORY / REVIEW OF SYSTEMS

	Now	Ever
Constitutional symptoms		
Unexplained fevers		
Unexplained weight loss		
Eye		
Glaucoma		
Cataract		
Dry eyes		
Serious visual disorder		
Ear/Nose/Mouth/Throat		
Hearing loss		
Ringing in ears		
Hoarseness		
Voice change		
Trouble swallowing		
Dry mouth		
Cardiovascular		
Heart attack		
Coronary bypass surgery		
High blood pressure		
High cholesterol		
Atrial fibrillation		
Respiratory		
Cough		
Shortness of breath		
Asthma		
Endocrine		
Diabetes		
Thyroid disorder		
Osteoporosis		
Gastrointestinal		
Liver problems		
Ulcers		
Stomach pain		
Crohn's or ulcerative colitis		
Eating disorder		
Cancer		
Type of cancer and year		

	Now	Ever
Genitourinary		
Blood in urine		
Pain on urination		
Abnormal menstrual periods		
Kidney stones		
Musculoskeletal		
Joint pain		
Back or neck pain		
Arthritis		
Fibromyalgia		
Skin/breast		
Skin rash		
Psoriasis		
Breast lumps		
Breast discharge		
Neurological		
Seizure		
Stroke		
Headaches		
Head/brain injury		
Psychiatric		
Anxiety		
Bipolar disease		
Suicidal attempt(s)		
Hematological/Lymphatic		
Problems with blood clotting		
Anemia		
Enlarged lymph nodes		
Leukemia / Lymphoma		

ALLERGIES	
Iodine (shellfish)	
Tape	
Latex	
Foods (specify):	
Environmental (specify):	
Medications (specify drug and reaction)	

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 ☐ Yes ☐ No
Mother	Living ☐ Yes ☐ 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

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?

_____

_____