Multiple Sclerosis Center

New Patient Information

SWEDISH NEUROSCIENCE INSTITUTE

Last Name: ____________________ **First Name:** ________________ **DOB:** _____________

With regard to your MS diagnosis, how can our office help you?

____

____

____

Multiple Sclerosis:

Date of Diagnosis: _________________________

When did you have your first symptom? ______

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

History of Symptoms				
Symptom	**Approx. Date**	**Took Steroids?**	**Resolved?**	**MS Therapy at the time**
Example: Blurry vision	*June 2010*	☒Yes ☐No	☒Yes ☐No	*Rebif*
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	
		☐Yes ☐No	☐Yes ☐No	

Medical Testing Completed:

☐MRI Brain Date: __________ Facility: ____________________

☐MRI Spine Date: __________ Facility: ____________________

☐Spinal Tap/Lumbar Puncture Date: __________ Facility: ____________________

☐Electromyogram/Nerve Study Date: __________ Facility: ____________________

(Electrical stimulus to the limbs with wires on your limbs. Needles placed into muscles to record.)

Other Medical Problems	Previous Surgeries

How did you hear about our clinic?

☐Friends/Family ☐MS Roadshow ☐Swedish Website

☐Physician/Provider ☐Radio/TV/Newspaper ☐Internet (Google, Bing, etc.)

☐National MS Society ☐MS Support Group ☐MS Educational Program

☐Other: ____

TURN OVER & COMPLETE BACK →

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Visual Symptoms

	Now	In the Past		Now	In the Past
Decreased Vision	☐	☐	Blurry Vision	☐	☐
Double Vision	☐	☐	Eye Pain	☐	☐

Motor Symptoms (Muscles)

	Now	In the Past
Weakness	☐	☐
Location:		
Location:		
Spasticity **(Stiffness/Cramping)**	☐	☐
Location:		
Location:		
Tremors/Incoordination	☐	☐
Imbalance/Dizziness	☐	☐
Restless Legs	☐	☐

How far can you walk without resting?

- ☐Less than 5 steps
- ☐Less than 20 yards
- ☐Less than 100 yards
- ☐Less than 500 yards
- ☐More than 500 yards (1/4 mile)
- ☐Unlimited

If you have falls due to MS, how many times did that happen in the last year?

Mobility Aids

	Now	In the Past		Now	In the Past
Ankle/Foot Orthosis	☐	☐	Wheelchair (asst. transfer)	☐	☐
Knee Orthosis	☐	☐	Power Wheelchair	☐	☐
Cane/Crutch	☐	☐	Restricted to chair	☐	☐
2 Canes/2 Crutches	☐	☐	Restricted to bed (can use arms)	☐	☐
Wheelchair (can transfer)	☐	☐	Restricted to bed (no arm use)	☐	☐

Sensory Symptoms

Numbness/Tingling	Now	In the Past
Location:	☐	☐
Location:	☐	☐
Spine tingling when bending neck	☐	☐
Pain		
Location:	☐	☐
Location:	☐	☐

Brainstem/Cerebellar

	Now	In the Past
Trigeminal Neuralgia	☐	☐
Dysarthria (slurred speech)	☐	☐
Dysphagia (trouble swallowing)	☐	☐

Bowel

Constipation (can't go)	☐	☐
Incontinence (uncontrolled)	☐	☐

Bladder

Urgency (can't wait)	☐	☐
Incontinence (uncontrolled)	☐	☐
Hesitancy (can't go)	☐	☐
Retention (incomplete voiding)	☐	☐
Urinary Catheter	☐	☐

Sexuality

Sexual concerns*	☐	☐

*your provider will discuss with you in more detail

Sleep & Fatigue

Insomnia	☐	☐
Fatigue	☐	☐
Snoring/Sleep Apnea	☐	☐

Mood & Cognition

Depression	☐	☐	Cognitive Impairment	☐	☐
Anxiety	☐	☐			

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Previous Treatments

Have you been treated with any of the following?:

Treatment		Approx. Dates:	Started:	Ended:
☐Aubagio (teriflunomide)		Approx. Dates:	Started: ______	Ended: ______
☐Avonex/Plegridy (Interferon beta-1a)		Approx. Dates:	Started: ______	Ended: ______
☐Betaseron/Extavia (Interferon beta-1b)		Approx. Dates:	Started: ______	Ended: ______
☐Copaxone/Glatopa (Glatiramer acetate)		Approx. Dates:	Started: ______	Ended: ______
☐Gilenya (fingolimod)		Approx. Dates:	Started: ______	Ended: ______
☐Lemtrada (alemtuzumab)		Approx. Dates:	Started: ______	Ended: ______
☐Novantrone (Mitoxantrone)		Approx. Dates:	Started: ______	Ended: ______
☐Ocrevus (ocrelizumab)		Approx. Dates:	Started: ______	Ended: ______
☐Rebif (Interferon beta-1a)		Approx. Dates:	Started: ______	Ended: ______
☐Tecfidera (dimethyl fumarate)		Approx. Dates:	Started: ______	Ended: ______
☐Tysabri (Natalizumab)		Approx. Dates:	Started: ______	Ended: ______
☐Zinbryta (daclizumab)		Approx. Dates:	Started: ______	Ended: ______
☐Cellcept (mycophenolate mofetil)		Approx. Dates:	Started: ______	Ended: ______
☐Imuran (azathioprine)		Approx. Dates:	Started: ______	Ended: ______
☐Rituxan (rituximab)		Approx. Dates:	Started: ______	Ended: ______
☐Other:	______________	Approx. Dates:	Started: ______	Ended: ______
☐Other:	______________	Approx. Dates:	Started: ______	Ended: ______

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

Tell us about the trial: ______________________________

Would you like to know about clinical trials at the Swedish MS Center? ☐Yes ☐No

Medications (use additional pages, if needed, but list medications and supplements separately)

Medication Name:	Mg or IU in each pill:	Taken how many times a day:

Supplements

Supplement Name:	Mg or IU in each pill:	Taken how many times a day:

Family History

	List Medical Illnesses
Father	
Mother	
Brother/Sister	
Children age ( )	
age ( )	
age ( )	
age ( )	

TURN OVER & COMPLETE BACK →

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Past Medical History & Review of Symptoms

Do you currently have any of the following?:

Constitutional Symptoms
☐Unexplained fevers
☐Unexplained weight loss
☐Night sweats

Eye
☐Glaucoma
☐Cataract
☐Lazy eye
☐Dry eyes

Ear/Nose/Mouth/Throat
☐Hearing Loss
☐Ear pain
☐Ringing in ears
☐Sinus problems
☐Mouth sores
☐Problems with teeth
☐Hoarseness
☐Voice change
☐Trouble swallowing

Neurological
☐Seizures
☐Loss of consciousness
☐Headaches
☐Head/brain injury

Cardiovascular
☐Chest pain/discomfort
☐Irregular heartbeat
☐High blood pressure
☐High cholesterol

Respiratory
☐Cough
☐Shortness of breath
☐Asthma
☐Pneumonia/influenza
☐Tuberculosis

Gastrointestinal
☐Frequent nausea or vomiting
☐Heartburn
☐Stomach pain
☐Blood in stool
☐Eating Disorder

Endocrine
☐Diabetes
☐Prior thyroid disease

Psychiatric
☐Bipolar disease
☐Suicide attempts
☐Have you been abused?

Genitourinary
☐Blood in urine
☐Pain on urination
☐Genital ulcers
☐Abnormal menstrual periods
☐Kidney stones

Musculoskeletal
☐Joint pain
☐Joint swelling
☐Back or neck pain
☐Arthritis

Skin/Breast
☐Sun sensitivity
☐Skin cancer
☐Skin rash
☐Breast lumps
☐Breast discharge

Hematologic/Lymphatic
☐Easy bruising
☐Problems with blood clotting
☐Enlarged lymph nodes

Gender Identity
Biologically: ____________
Preferential:

Allergies

☐Iodine (shellfish) ☐Tape ☐Latex
☐Food (list): ☐Environmental (list): ☐Medications (list drug & reaction):

____________ ____________ ____________

Habits

What exercise do you perform?: ____________

What hobbies do you have? ____________

Smoker: ☐Never ☐Previously ☐Currently ________ packs/day for ________ years

Alcohol: ☐Never ☐Previously ☐Currently ________ drinks/day for ________ years

Marijuana Use: ☐Never ☐Previously ☐Currently ________ /day for ________ years

Other drug use: ☐Never ☐Previously ☐Currently ________ /day for ________ years