MS Care Clinic
Medical Information

Date: ______________________ **Name:** ______________________________

Age: __________ **Date of Birth:** _____/_____/_______ **Sex:** ________________

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed/Widow

How did you hear about MS Care Clinic? _____________________________________

What brings you to see us? ____

____

____

What pharmacy do you use? ____

When did your problem[s] start? ____
Have you ever had this problem before? ☐ **Yes** ☐ **No**

Describe your problem/pain: ☐Burning ☐Sharp ☐Shooting
☐Stabbing ☐Aching ☐ Dull ☐ Pounding ☐Squeezing
☐ Stiffness ☐Tightness ☐ I do not have any pain

Have you taken *<u>any</u>* medications for these problems[s]? ☐Yes ☐ No
Please list any medications you have taken for these problem[s]:

____________________________ Did this help? ☐Yes ☐ No

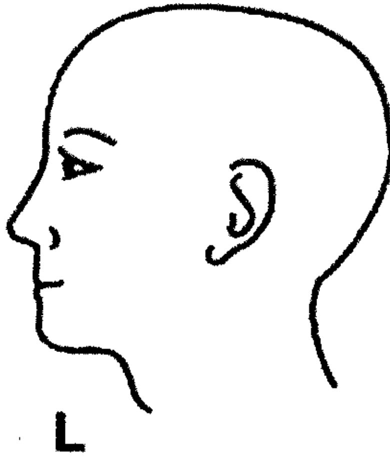
____________________________ Did this help? ☐Yes ☐ No

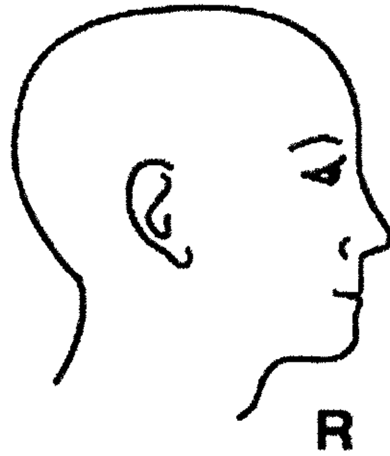
____________________________ Did this help? ☐Yes ☐ No

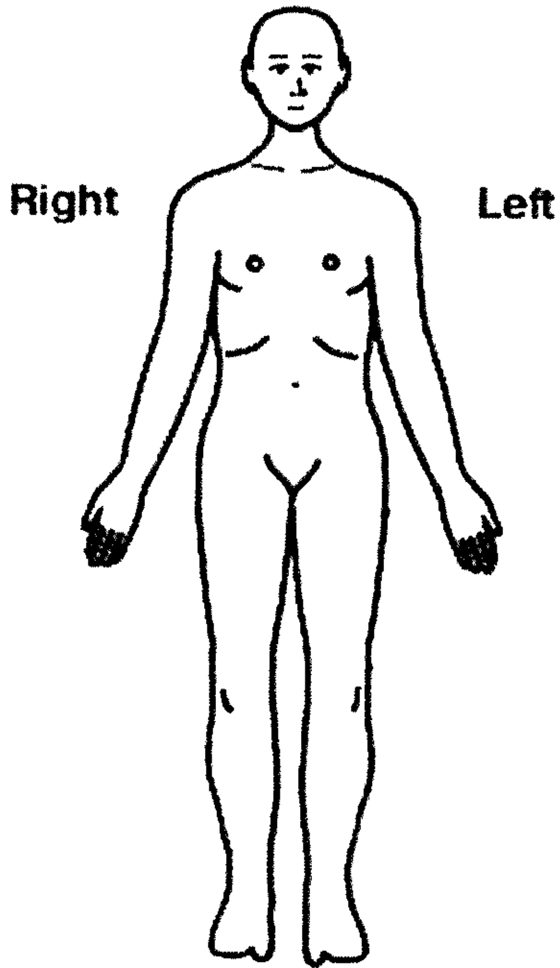
____________________________ Did this help? ☐Yes ☐ No

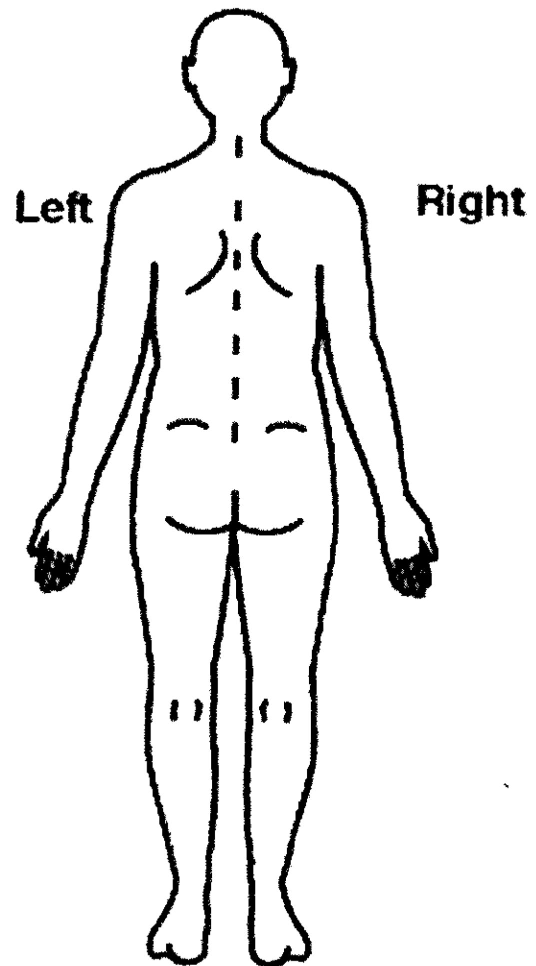
____________________________ Did this help? ☐Yes ☐ No

What part of your body is affected? Mark all that apply:









Does anything make your problem worse? ☐ Any Activity ☐ Sitting/Resting

Does anything make your problem better? ☐Resting ☐ Movement

How bad is this affecting your life?
☐ Mild ☐ Moderate ☐ Severe ☐ Extreme ☐ None

What test[s] have you had done specific to your problem?
☐ MRI [Brain] ☐ MRI [Spinal] ☐ CT Scan ☐ Lab work
☐ EMG/NCS [muscle/nerve test] ☐ EEG [seizures] ☐ ________________

What do you hope is accomplished with today's visit?

____

____

____

____

Medical History

Who is your Primary Care Doctor? ______________________________
Are you allergic to any medications? ☐ **Yes** ☐ **No**
Please list your allergies: ______________________________
____
____

What health problems do you currently have or have previously had:
☐High Blood Pressure [Hypertension] ☐Diabetes
☐Stroke / TIA ☐Sleep Apnea ☐ Heart Disease
☐Depression ☐Anxiety ☐Bipolar
☐Bleeding disorder ☐Anemia ☐HIV / AIDS
☐Hepatitis ☐ A ☐ B☐ C ☐ High Cholesterol
☐Seizures ☐ Concussions / Loss of Consciousness
☐ Arthritis ☐ Asthma ☐ COPD / Emphysema / Bronchitis
☐Osteoporosis ☐ Headaches ☐Thyroid Disease
☐Cancer ☐Skin issues ☐ Reflux
☐Other: ____

What medications do you take every day?

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

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How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________ Dose: ______________________
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

What medications do you take as needed? Vitamins etc.,

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
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☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

☐ ______________________________ Dose: ____
How often: ☐Once a day ☐ Twice a day ☐ Three times a day
☐ Four or more times a day

Tell us about your family

Father	☐ Living ☐Deceased	_________Age	☐High Blood Pressure ☐ Diabetes☐ Cancer ☐Stroke ☐ Cholesterol ☐Other:
Mother	☐ Living ☐Deceased	__________Age	☐High Blood Pressure ☐Diabetes☐ Cancer ☐Stroke ☐ Cholesterol ☐Other:
Brothers	# Living _________ # Deceased _____	Age: _________ Age: _________ Age: _________ Age: _________	☐High Blood Pressure ☐Diabetes☐ Cancer ☐Stroke ☐Cholesterol ☐Other:
Sisters	# Living _________ # Deceased _____	Age: _________ Age: _________ Age: _________ Age: _________	☐High Blood Pressure ☐Diabetes☐ Cancer ☐Stroke ☐Cholesterol ☐Other:
Children	# Living _________ # Deceased _____	Age: _________ Age: _________ Age: _________ Age: _________	☐High Blood Pressure ☐Diabetes☐ Cancer ☐Stroke ☐Cholesterol ☐Other:

Social History:

Do you smoke? ☐Yes☐ No If yes; what do you smoke?

☐Cigarettes # packs per day _______ # years _________

☐Pipe ☐Cigars ☐ Chewing tobacco ☐ Skoal / Copenhagen

☐Vape

How much Alcohol do you drink weekly:
☐None ☐Socially ☐Daily ☐ Heavy

Do you use any illegal drugs: ☐Yes ☐No

Do you use Marijuana? ☐Yes ☐No

Have you ever been in rehab for drugs? ☐Yes ☐ No

Have you ever been in rehab for alcohol? ☐ Yes ☐No

How often do you exercise?☐Daily☐2x a week☐3x a week☐ 4x a wk

Are there any religious beliefs that might affect your medical care? ☐Yes ☐No

Please circle your highest level of education: ☐Grade School ☐GED
☐ High School ☐ College Degree ☐ Doctorate Degree

What type of work do you do? ____________________

Does your health problems interfere with your work performance? ☐Yes ☐No
If yes; please explain: ____________________

____

List all surgical procedures you have had:

____________________ Date ____________________

____________________ Date ____________________

____________________ Date ____________________

____________________ Date ____________________

____________________ Date ____________________

I have provided my health information to the best of my ability.

Signature: ____________________

Name: ______________________________ Today's Date: ______________________

REVIEW OF SYSTEMS

For new patients, established patients who may be having a new problem, or our patients who we haven't seen for a while, we need to update our records as to your general medical health. In each area, if you are not having any difficulties, please check "No Problems." If you are experiencing any of the symptoms listed, **PLEASE CIRCLE THE ONES THAT APPLY**, or explain any that may not be listed. If you have any questions about this, please ask one of the technicians, or your doctor.

Const. (Health in General) ❑ No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ______________________________

Ears, Nose, Mouth & Throat ❑ No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________________________

C-V (Heart & Blood Vessels) ❑ No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________________

Resp. (Lungs & Breathing) ❑ No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ______________________________

GI (Stomach & Intestines) ❑ No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ______________________________

GU (Kidney & Bladder) ❑ No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________________________

MS (Muscles, Bones, Joints) ❑ No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ______________________________

Integ. (Skin, Hair & Breast) ❑ No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ______________________________

Neurologic (Brain & Nerves) ❑ No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ______________________________

Psychiatric (Mood & Thinking) ❑ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________________

Endocrinologic (Glands) ❑ No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________________

Hematologic (Blood/Lymph) ❑ No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ______________________________

Allergic/Immunologic ❑ No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ______________________________

Center for Neurologic Study-Lability Scale (CNS-LS) for pseudobulbar affect (PBA)

The CNS-LS is a short (seven-item), self-administered questionnaire, designed to be completed by the patient, that provides a quantitative measure of the perceived frequency of PBA episodes. The CNS-LS can help physicians accurately diagnose PBA. A CNS-LS score of 13 or higher may suggest PBA.

Patient's name: ______________________________

Date of assessment: ______________________________

Using the scale below, please write the number that describes the degree to which each item applies to you DURING THE PAST WEEK. Write only 1 number for each item.

Applies never	Applies rarely	Applies occasionally	Applies frequently	Applies most of the time
1	2	3	4	5

	Assessment questions	Answers
1	There are times when I feel fine 1 minute, and then I'll become tearful the next over something small or for no reason at all.	
2	Others have told me that I seem to become amused very easily or that I seem to become amused about things that really aren't funny.	
3	I find myself crying very easily.	
4	I find that even when I try to control my laughter, I am often unable to do so.	
5	There are times when I won't be thinking of anything happy or funny at all, but then I'll suddenly be overcome by funny or happy thoughts.	
6	I find that even when I try to control my crying, I am often unable to do so.	
7	I find that I am easily overcome by laughter.	

Total Score: ______________

The CNS-LS has been validated in ALS and MS patient populations.

This questionnaire is not intended to substitute for professional medical assessment and/or advice.

Reference: Moore SR, Gresham LS, Bromberg MB, Kasarkis EJ, Smith RA. A self report measure of affective lability. *J Neurol Neurosurg Psychiatry.* 1997;63(1):89-93.

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Patient Health Questionnaire (PHQ-9)

Name:______________________________ Date: ______________________

DOB:____________________

Over the *past 2 weeks,* how often have you been bothered by any of the following problems? ***(use "✓" to indicate your answer)***	Not at all	Several Days	More Than Half the Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: ______ + ______ + ______

*(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.)***Total:** ______

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	
	Not difficult at all ______
	Somewhat difficult ______
	Very difficult ______
	Extremely difficult ______