

PATIENT QUESTIONNAIRE

*Dr. Kathleen Hawker MD
Dr. D. Joanne Lynn MD
Dr. Michael Racke MD
Dr. Kottil Rammohan MD*

THIS QUESTIONNAIRE MUST BE COMPLETED AND RETURNED ALONG WITH DOCUMENTATION OF ANY PREVIOUS WORK-UP (i.e. MRI FILMS AND MEDICAL RECORDS) FOR REVIEW "PRIOR TO SCHEDULING."

PLEASE SEND RECORDS, QUESTIONNAIRE AND FILMS TO: The Ohio State University MS Center, 2050 Kenny Road, Suite 2250, Columbus, OH 43221

YOUR NAME: _____ **AGE:** _____

TODAY'S DATE: _____ **DATE OF BIRTH:** _____

ADDRESS: _____

HOME PHONE NUMBER: _____ **WORK PHONE:** _____

CELL PHONE: _____ **PHARMACY NAME (USUAL):** _____

PHARMACY ID#: (If Applicable) _____ **PHARMACY PHONE:** _____

ARE YOU: _____ **LEFT HANDED OR** _____ **RIGHT HANDED**

PLACE OF BIRTH: _____

PLACE/S LIVED BEFORE AGE 15: _____

NAME AND ADDRESS OF YOUR FAMILY MD:

SELF REFERRED: **YES OR NAME AND ADDRESS OF REFERRING MD:**

IS THE REFERRING MD AT OHIO STATE UNIVERSITY? **Y** **N**

Please answer these questions to the best of your ability. There is room at the end of each section for additional comments. PLEASE GIVE NECESSARY DETAILS FOR YES ANSWERS. We realize that this form is long, but when it is filled out carefully, it allows us to devote more time to your specific problem, rather than asking you related questions during your visit.

Please describe the reason why you are seeing us. _____

Please describe to us in detail the symptoms you have had from the onset and when they occurred in a time sequence. Exactly when did your problem begin? What might have caused the problem to begin? (Infection, stress, accident?). Please include details concerning the **diagnostic tests and treatments that you have received for these symptoms** and the results of any tests and **your response to any treatments given:** _____

What have you been told this problem is due to? (Diagnosis) _____

What do **YOU** personally think your problem is due to? _____

1. NEUROLOGIC/MS HISTORY (please give details)

√	Description of syndrome	When?	Ongoing?	Treatments received	Benefit?
	Fatigue				
	- Generalized				
	- Does it get worse post exercise?				
	- Do you wake up feeling tired?				
	Sleep problems:				
	- Getting to sleep				
	- Staying asleep				
	- Waking up multiple times				
	- Early am awakening				
	- Snoring				
	- Leg kicking/restless				
	Depression				
	Symptoms made worse by heat (if yes, please specify symptom)				
	Trouble with walking				
	Muscle weakness (where?)				
	Trouble with balance				
	Problem with balance in the dark or with your eyes closed				
	Any falls?				
	- How often?				
	- Any injuries?				
	Do you use any of the following?				
	- Leg braces				
	- Cane				
	- Crutches				
	- Walker				
	- Standard wheelchair				
	- Electric wheelchair				
	- Scooter				
	Impaired vision				
	- Double vision				
	- Blurred vision <input type="checkbox"/> left <input type="checkbox"/> right				
	- Flashes of light				
	- Jumping of vision				
	- Trouble reading				
	- Crossed eye/lazy eye				
	- Problems w/ color vision?				
	- Do you wear glasses? <input type="checkbox"/> reading <input type="checkbox"/> far viewing <input type="checkbox"/> both				
	Electric shock-type sensation when bending your neck or with handwriting				
	Problems with speech – if yes, please describe problem				
	Seizures				
	Face pain				

	Lightheadedness				
√	Description of syndrome	When?	Ongoing?	Treatments received	Benefit?
	Problems with memory				
	- Word finding				
	- Concentration				
	- Slowness or problem with tasks				
	- Learning new material				
	Difficulty swallowing				
	Spinning sensations				
	Numbness or pins/needles in part of your body (where?)				
	Cramps/Spasms of limbs				
	Tightness/Stiffness of limbs				
	- Limitation of activity due to above				
	- Pain due to above				
	Tremors				
	Diarrhea				
	- Frequent bowel movements				
	- Urgency				
	Bowel problems				
	-Difficulty evacuating bowels				
	-Less frequent bowel movements				
	-More frequent bowel mvmts				
	- Consistency of stool: hard, loose, normal				
	Bladder problems				
	- Frequent urination				
	- Do you get strong urges to urinate?				
	- have you ever lost control of your bladder?				
	- If so, was it related to cough/sneeze or laughing?				
	- Do you ever have difficulty starting to urinate?				
	- Do you feel like you don't empty your bladder completely?				
	- Have you had bladder infection? How often?				
	- Have you seen a bladder specialist?				
	- If yes, did you have tests run?	Which tests?			
	- Have you had bladder or kidney stones?				
	Problems with sexual function				
	- including: interest in sex, sensation, arousal, erection, ejaculation, lubrication, orgasm?				

2. PREVIOUS WORK-UP: Have you had a:

√	Description of syndrome	When?	Results
	Evaluation by a neurologist		
	Evaluation by an eye doctor		
	Evaluation by a psychologist/psychiatrist		
	MRI of the brain Was contrast dye given by injection?		
	MRI of the neck/spinal cord		
	CT scan of the head or neck		
	Neck X-rays		
	Arteriogram or blood flow studies of the brain/neck vessels		
	BAER (auditory evoked potentials = EP)		
	SSEP (somatosensory EP)		
	VER (visual EP)		
	Myelogram		
	Lumbar puncture (i.e. spinal tap or spinal fluid examination)		
	EEG (brain wave)		
	EMG/NCS (examination of muscles and nerves by electric stimuli)		
HAVE YOU RECENTLY HAD A:			
	Blood work		
	Urinalysis		
	Chest X-ray		
	Bone density/DEXA scan (for osteoporosis)		
	Mammogram		
	Echocardiogram		
	Lyme test		
	Glucose tolerance test (sugar)		
	Vitamin B12 test		
	Thyroid test		
	AIDS/HIV test		

3. MS MEDICATION HISTORY:

Have you ever received any of the following medications?

√	Name of the medicine	Date started	Date stopped	Results	Side effects/Reactions
	Betaseron				
	Avonex				
	Copaxone				
	Rebif				
	Steroids for MS attack Prednisone, dexamethasone,				

	solumedrol, methylpredni- solone by vein or mouth			
√	Name of the medicine	Dates given?	Results	Side effects/Reactions
	Steroids regularly for disease control (please specify dose & time interval)			
	Cyclophosphamide (cytoxan)			
	Methotrexate			
	IVIg			
	Azathioprine (Imuran)			
	Cellcept (Mycophenolate)			
	Natalizumab (Tysabri)			
	Plasma exchange			
	Bone marrow transplantation			
	Others (specify)			
	Experimental MS therapy as a part of clinical trial (specify)			

4. ALLERGIES TO MEDICATIONS:

	Name of the medicine	Description of reaction
1		
2		
3		
4		
5		
6		

5. CURRENT MEDICATIONS:

Include hormones, birth control pills, vitamins, supplements, calcium, special diet and over the counter drugs

	Name of the medicine	Dose and frequency/time of the day
1		
2		
3		
4		
5		
6		

7		
8		
9		
10		
11		
12		
13		
14		
15		

6. PAST MEDICAL HISTORY: Have you had/been diagnosed with following disorders?
Mark all that apply:

<input type="checkbox"/> Cardiovascular problems:	<input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol <input type="checkbox"/> heart attack <input type="checkbox"/> stroke <input type="checkbox"/> Clot leg or lung <input type="checkbox"/> Problems with bleeding <input type="checkbox"/> Other _____
<input type="checkbox"/> Lung problems:	<input type="checkbox"/> COPD (Chronic obstructive pulmonary disease) <input type="checkbox"/> Asthma <input type="checkbox"/> Pneumonia <input type="checkbox"/> Sarcoidosis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other _____
<input type="checkbox"/> Gastrointestinal problems:	<input type="checkbox"/> Stomach ulcers/high acid <input type="checkbox"/> Inflammatory bowel disease <input type="checkbox"/> Irritable bowel syndrome <input type="checkbox"/> Gluten sensitivity <input type="checkbox"/> Other _____
<input type="checkbox"/> Kidney/ Bladder Problems:	<input type="checkbox"/> Inflammation <input type="checkbox"/> Kidney stones <input type="checkbox"/> Other _____
<input type="checkbox"/> Endocrine problem:	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid problem <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Other _____
<input type="checkbox"/> Blood disorder:	<input type="checkbox"/> Anemia <input type="checkbox"/> problem with blood clotting/bleeding <input type="checkbox"/> Other _____
<input type="checkbox"/> Rheumatological disorders:	<input type="checkbox"/> Rheumatoid arthritis <input type="checkbox"/> Lupus <input type="checkbox"/> Sjogren's syndrome <input type="checkbox"/> Other _____
<input type="checkbox"/> Ear problems:	<input type="checkbox"/> Ear infections <input type="checkbox"/> Inner ear disease <input type="checkbox"/> Sinus disease <input type="checkbox"/> Other _____
<input type="checkbox"/> Eye problem:	<input type="checkbox"/> Cataract <input type="checkbox"/> Inflammation <input type="checkbox"/> Night blindness <input type="checkbox"/> Optic Neuritis <input type="checkbox"/> Other _____
<input type="checkbox"/> Infectious diseases:	<input type="checkbox"/> Lyme disease <input type="checkbox"/> Syphilis <input type="checkbox"/> Other sexually-transmitted disorders <input type="checkbox"/> Mononucleosis (Ebstein Barr) at age _____ <input type="checkbox"/> Measles <input type="checkbox"/> Other _____
<input type="checkbox"/> Neurological problems:	<input type="checkbox"/> Disease of the leg/arm nerves <input type="checkbox"/> Spinal cord disease <input type="checkbox"/> Sciatica <input type="checkbox"/> Muscle disease <input type="checkbox"/> Epilepsy <input type="checkbox"/> Brain infection <input type="checkbox"/> Spinning/vertigo <input type="checkbox"/> Headache-Type-_____ <input type="checkbox"/> Other _____
<input type="checkbox"/> Psychiatric disorders:	<input type="checkbox"/> Depression <input type="checkbox"/> Bipolar disorder <input type="checkbox"/> Schizophrenia <input type="checkbox"/> Anxiety <input type="checkbox"/> Other _____
<input type="checkbox"/> Cancer:	Type: _____ When diagnosed? _____ <input type="checkbox"/> Received chemotherapy: _____ <input type="checkbox"/> Received radiation to brain: when? _____

7. PAST SURGICAL HISTORY:

Have you had any surgery? Please describe details (what kind, when): _____

8. OCCUPATIONAL/TOXIC/INFECTIOUS EXPOSURES:

Have you been exposed to any of the following? If yes, please describe the details of the exposure and when it occurred:

Poison, gases, chemicals _____
 Tropical diseases _____
 Tick bites _____
 Military service overseas _____
 Travel to Central or South America, Asia, Africa, Australia _____
 AIDS _____
 Blood transfusions within 15 years _____

9. SOCIAL HISTORY:

What is your present occupation? _____
Employer: _____ Working hours per week: _____
Prior occupation: _____
If you are disabled, when did this occur? _____ And why? _____
Education completed: _____
Are you: Single Married Divorced Widowed
Who do you live with? _____

Do you drink alcohol? How much alcohol do you drink during an average week? _____
 Have you quit drinking? If so when did you quit? _____
How much did you drink per week? _____

Do or did you ever smoke cigarettes?
If so, how many packs/day _____
What age did you start _____
If you quit, at what age? _____

Do or did you ever smoke cigars, pipes, or chews tobacco?
 Do you now, or did you ever use street drugs? (LSD, Cocaine, Marijuana, Speed, IV Drugs?)
 Do you drink coffee, decaf or sodas frequently? (More than 2/day)
If yes, how much do you drink each day? _____

Do you have any pets? _____
 Do you have children? What are their ages? _____

--

10. FAMILY HISTORY:

Are there any family members (grandparents, parents, siblings, children or more distant relatives with: (if yes, please indicate which family member)

√	Description of condition/disease	Affected family member(s)
	The same condition you have	
	Multiple Sclerosis	
	Other autoimmune disorders: Rheumatoid arthritis, Lupus, Psoriasis, Inflammatory bowel disease (Crohn's or ulcerative colitis), Thyroid (Graves/ Hashimotos), Vitamin B12 deficiency Others:	
	Migraine headaches	
	Vertigo or dizziness	
	Balance problems	
	Tremor	
	Convulsions or seizures	
	Diabetes	
	Cancer: Type?	
	Brain tumors	
	Stroke	
	Heart disease	
	High blood pressure	
	Psychiatric disorders (depression, anxiety,...)	
	Peripheral nerve problem	
	Dementia/ Alzheimers / Confusion	
	Any other condition that run in the family:	

If your grandparents, parents, brothers and sisters, or any children have died, please describe at what age and from what cause:

11. REVIEW OF SYSTEMS:

Have you/do you experience any of the following? If yes, please give details.

√	Description of a problem	Date of onset	Ongoing?	Details
---	--------------------------	---------------	----------	---------

	Weight loss: how much?			
	Weight gain: how much?			
	Rash			
	Sores in mouth and/or genitals			
√	Description of a problem	Date of onset	Ongoing?	Details
	Fevers or swollen glands			
	Abnormal menstrual periods			
	Shortness of breath			
	Chest pain			
	Palpitations (irregular or fast beating of the heart)			
	Loss of consciousness			
	Milky discharge from breast			
	Dry eyes or dry mouth			
	Sense of smell disorder			
	Sense of taste disorder			
	Hearing problems			
	Hair loss			
	Black or bloody stool			
	Sweating/cold feelings			
	Stomach pain			
	Acid reflux			
	Problems with digestion			
	Pain in back of jaw (TMJ), grinding			
	Neck pain			
	Lower back pain			
	Any other medical problems you may be experiencing			
	Headaches			Frequency during the last 6 month _____ Pain intensity (1-10 with 10 being most severe): _____ <input type="checkbox"/> throbbing or pulsatile in quality <input type="checkbox"/> associated with nausea and/or vomiting <input type="checkbox"/> are brought on by cough/sneeze/strain <input type="checkbox"/> are preceded by bright or flashing lights/lines <input type="checkbox"/> require medication for pain: _____ <input type="checkbox"/> if untreated, prevents you from doing usual activities

**YOU MADE IT TO THE END OF THIS QUESTIONNAIRE!
CONGRATULATIONS, AND THANK YOU VERY MUCH!**