NEW PATIENT FORM Multiple Sclerosis Care Center

Dr. Heyman, Dr. Xia, Dr. Isitan Alkawadri, Dr. Appleberry, Dr. Loma-Miller, Dr. Brayo
Emily Eiben CRNP, Emily Guerriero PA-C, and Natalie Whiteko, PA-C

Name: _____ **Date of birth:** _____

Marital Status: _____ **Please circle one:** Mr. Mrs. Ms. Miss Dr.

Address: _____

_____

Home Phone: (_____) _____ **Cell Phone:** (_____) _____

Email Address: _____ **Work Phone:** (_____) _____

Preferred Contact: ☐ home ☐ cell ☐ MyUPMC secure portal

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Home Phone: (____) _____
Cell Phone: (_____) _____

_____

PCP (Primary Care Physician): *(for continuing care from our practice we require regular follow up with a PCP)*

Name: _____ Phone Number: (____) _____

Address: _____ Fax Number: (____) _____

_____

_____

Referring Physician:

Name: _____ Phone Number: (____) _____

Address: _____ Fax Number: (____) _____

_____

Insurance Company:

Medical insurance company: _____

Pharmaceutical insurance company: _____

Pharmacy (local):

Name: _____ Phone Number: (____) _____

Address: _____ Fax Number: (____) _____

_____

_____

Pharmacy (mail order):

Name: _____ Phone Number: (____) _____

Address: _____ Fax Number: (____)_____

_____

_____

Pharmacy (specialty):

Name: _____ Phone Number: (____) _____

Address: _____ Fax Number: (____) _____

_____

_____

Why did you schedule this appointment?

_____

_____

_____

_____

_____

_____

NEUROLOGICAL DIAGNOSTIC TESTING HISTORY:

What health care evaluations and tests have already been done for your diagnosis?

Evaluation or Test	Approximate Date	Location where test was completed	Results
MRI – Brain (Most recent)			
MRI – Brain (initial)			
MRI – Cervical Spine (initial)			
MRI – Cervical Spine (most recent)			
MRI – Thoracic Spine (initial)			
MRI – Thoracic Spine (Most recent)			
Lumbar Puncture (Spinal Tap initial)			
Lumbar Puncture (Spinal Tap, repeat)			
Visual Evoked Potentials			
Median (Arm) Sensory Evoked Potential			
Tibial (Leg) Sensory Evoked Potential			
NMO Blood Test			
MOG Test			

List all medications you have taken for your MS/ immunologic disorder:

Injectable: Avonex, Betaseron, Copaxone, Extavia, Glatiramer Acetate, Glatopa, Kesimpta, Plegridy, Rebif

Oral: Aubagio, Bafiertam, Cellcept, Dimethyl Fumarate, Gilenya, Mavenclad, Mayzent, methotrexate, Mycophenolate, Ponvory, Tecfidera, Vumerity, Zeposia **Infusions:** Lemtrada, Novantrone (mitoxantrone), Ocrevus, Tysabri

MS/Immune Medication	Date Started	Date Stopped	Reason for stopping

Have you ever taken Ampyra/dalfampridine? _____

Have you ever received IV steroids for your neurologic condition? _____
If yes, when: _____

PAST MEDICAL HISTORY: Have you ever been diagnosed or treated for any of the following conditions?
If yes, please list the date they started.

Medical Condition	Onset	Medical Condition	Onset	Medical Condition	Onset
High blood pressure		Liver problems		Diabetes	
High cholesterol		Thyroid problems		Neck or back injury	
Heart problems (attacks, failure, A-fib, etc.)		breathing problems: asthma, emphysema, bronchitis		Ulcers, gastritis, reflux,	
Stroke, ministroke, TIAs		Seizures		Ulcerative colitis, Crohn's disease	
Cancer or tumors		Lupus or rheumatoid arthritis		Head injury or concussion	
Anxiety, depression, "nerves"		Blood clots, thrombosis, embolism		Glaucoma, cataracts, macular degeneration	
Kidney problems		Migraine or headache		Drug and/or alcohol dependence or overuse	

Please list all operations, surgeries, deliveries, and other hospitalizations: *(including stents, devices, ports, pacemakers, pumps, etc.)*

Date (Year)	Reason for Hospitalization	Hospital & City

SOCIAL HISTORY:

Place of birth: _____ Hand dominance: ☐ right ☐ left ☐ ambidextrous

Highest level of education: _____ Occupation: _____

Any interesting facts we you want us to know about you? _____

SUBSTANCE USE:

Alcohol use ☐ never ☐ not in last 6 months ☐ yes, if yes, how often do you consume alcohol?
☐ 1 time/month or less ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4+ times/week

Tobacco use ☐ never ☐ not currently I quit in _____ ☐ current some day smoker
☐ Current daily smoker, _____ packs per day

If tobacco user, identify types of tobacco use (check all that apply)
☐ cigarettes ☐ cigars ☐ pipe ☐ snuff ☐ chewing tobacco

Do you use any other forms of nicotine besides tobacco? ☐ Vaping ☐ gum ☐ patch

How often? ☐ weekly or less ☐ 2-5 times/week ☐ Daily ☐ More than once/day

Marijuana, THC use (any medical or recreational use) ☐ Yes ☐ No

If yes, check the types used: ☐ drops/tincture ☐ cigarettes ☐ pipe ☐ vaping/e-cigarette
☐ edibles ☐ topical/creams

How often? ☐ once/month or less, ☐ 2-4 times/month ☐ 2-3 times/week ☐ 4+ times/week

FAMILY HISTORY: Do you have a family history of any of the following, please list relation of person.

Condition	Relative
Multiple Sclerosis	
Autoimmune Disorders *(such as: Lupus, Rheumatoid Arthritis, Sjogren's, Inflammatory Bowel Disease)*	
Neurologic condition	
Diabetes Mellitus	
Mental Health	
Substance Abuse (drug or alcohol)	
Other:	

Current Medications, Injections, & Supplements Taken:

Please include any vitamins, supplements, pain relief, cold medication, shots, topical creams/patches, sprays, suppositories, injections, and all intermittent infusion.

If you have a typed list of your current medications containing all this information, please skip this section and attach the medication list.

Medication	Pill Size/Strength	How Many/How Often

Allergies/Sensitivity:

Medication/Substance	Reaction	Medication/Substance	Reaction

This Appointment Status Report

What is your diagnosis? ☐ Multiple Sclerosis ☐ NMO ☐ Possible MS ☐ other: _____

How do you feel you are doing? ☐ improved ☐ stable ☐ somewhat worse ☐ a lot worse

Please list your **most important** questions/issues for today's appointment (maximum of 3):

1) _____

2) _____

3) _____

How often do you exercise? ☐ never ☐ 1/week or less ☐ 2-3/week ☐ more than 3/week

Do you take a vitamin D supplement? ☐ yes ☐ no

Do you smoke tobacco? ☐ yes ☐ no

How is the stress level in your home? ☐ low ☐ moderate ☐ high ☐ very high

Are you currently working? ☐ yes, full time ☐ yes, part time ☐ no, unemployed

☐ on disability ☐_____

1. Do you have excessive fatigue? ☐ no ☐ mild ☐ moderate ☐ severe
2. Do you awaken refreshed from sleep? ☐ yes ☐ no
3. Do you have decreased muscle power in your right arm? ☐ no ☐ mild ☐ moderate ☐ severe
4. Do you have decreased muscle power in your right leg? ☐ no ☐ mild ☐ moderate ☐ severe
5. Do you have decreased muscle power in your left arm? ☐ no ☐ mild ☐ moderate ☐ severe
6. Do you have decreased muscle power in your left leg? ☐ no ☐ mild ☐ moderate ☐ severe
7. Do you have decreased muscle power in your trunk? ☐ no ☐ mild ☐ moderate ☐ severe
8. Do you have any muscle stiffness, spasms, or contractions? ☐ no ☐ yes, check where below:

   ☐ right arm ☐right leg ☐ left arm ☐ left leg
9. Do you currently have numbness or tingling? ☐ no ☐ yes, check where below:

   ☐ right arm ☐right leg ☐ left arm ☐ left leg ☐ face/ head ☐ whole body
10. Do you currently have any tremors or shaking? ☐ no ☐ yes, check where below:

    ☐ right arm ☐right leg ☐ left arm ☐ left leg ☐ face/ head ☐ whole body

11. Do you currently have pain anywhere? ☐ no ☐ yes, check where: ☐ head

☐ right arm ☐right leg ☐ left arm ☐ left leg ☐ face/ head ☐ whole body ☐ back/spine

12. Have you fallen in the last 12 months? ☐ No ☐ Once ☐ Less than 1 fall/month ☐ More than 1 fall/month

☐ More than 1 fall/week

12. Do you use an assistive device for mobility? ☐ no ☐ If yes, please check below all that apply:

☐ straight cane/pole ☐ multiprong cane ☐ standard walker ☐ rolling walker

☐ power wheelchair ☐ wheelchair ☐ scooter

13. Are you having any vision problems: ☐ no: go to question 14 ☐ if yes check below

a. Blurred vision? ☐ right eye ☐ left eye ☐ both eyes
b. Enlarged blind spot or missing parts of your vision? ☐ right eye ☐ left eye ☐ both eyes
c. Loss of color vision or decreased brightness? ☐ right eye ☐ left eye ☐ both eyes
d. Eye pain? ☐ right eye ☐ left eye ☐ both eyes
e. Double vision? ☐ constantly ☐ intermittently ☐ when looking right ☐ when looking left
f. Jumpy or jerky vision? ☐ constantly ☐ intermittently ☐ when looking right ☐ when looking left

14. Do you have difficulty controlling your bladder? ☐ no ☐ yes, check answers problem type below

☐urgency/rushing ☐ slowness to start urinating ☐ need to empty again soon after going

15. How often do you lose control of your urine?

☐ never ☐ rarely ☐ sometimes ☐ almost daily ☐ at least once/day

16. On a typical night, how often do you need to empty your bladder?

☐ 0-1 time ☐1-2 times ☐ 2-3 times ☐ more than 3 times

17. Do you ever use a catheter to empty your bladder?

☐ no ☐ external male catheter ☐ foley (urethral) catheter

☐ self-intermittent catheter (_____ times a day) ☐ suprapubic catheter

18. Do you require pads, diapers, or other incontinence products?

☐ never ☐ some days ☐ daily

19. How many bladder infections have you had in the last year? ☐ 0 ☐ 1 ☐ 2 ☐ 3 or more

20. Do you have bowel trouble?

☐ no problems ☐ diarrhea ☐ constipation ☐ incontinence ☐ staining/seepage

21. How frequently do you usually have a bowel movement? (Choose one.)

☐ more than once/day ☐ once daily ☐ 3-6 times/week ☐ weekly or less often

22. Have you had difficulty with:

a. swallowing ☐ yes ☐ no

b. frequent cough with eating ☐ yes ☐ no

c. food going "down the wrong pipe" ☐ yes ☐ no

23. Have you had difficulty with:

d. memory ☐ yes ☐ no

e. word recall ☐ yes ☐ no

f. problem solving ☐ yes ☐ no

g. planning ☐ yes ☐ no

h. organizing ☐ yes ☐ no

i. decision making ☐ yes ☐ no

23. Over the past two weeks, how often have you been bothered by any of the following problems?

A) Little interest or pleasure in doing things:

☐ not at all ☐ several days ☐ more than ½ the days ☐ nearly every day

B) Feeling down, depressed, or hopeless:

☐ not at all ☐ several days ☐ more than ½ the days ☐ nearly every day

Review of Systems: **Complete for the last 12 months timespan:**

24. Is your weight ☐ stable ☐ gained > 5 pounds ☐ lost > 5 pounds
25. Have you had any blackouts or fainting? ☐ yes ☐ no
26. Have you had any seizures? ☐ yes ☐ no
27. Have you noticed any blood in your urine? ☐ yes ☐ no
28. Have you noticed any blood in your stool/bowel movements? ☐ yes ☐ no
29. Do you have any open wounds or sores on your skin? ☐ yes ☐ no
30. Have you had any increase in your blood sugar? ☐ I don't know ☐ yes ☐ no
31. Do you have dry eyes? ☐ yes ☐ no
32. Have you been having chest pains? ☐ yes ☐ no
33. Have you been having irregular heart rate or rhythm? ☐ yes ☐ no
34. Have you had any dental or dry mouth problems? ☐ yes ☐ no
35. Do you have any red swollen joints? ☐ yes ☐ no
36. Have you had any hallucinations? ☐ yes ☐ no
37. Do you have breathing problems? ☐ no ☐ only with activity ☐ even while at rest
38. Have you had pneumonia? ☐ yes ☐ no

Patient Determined Disease Steps

Please read the choices listed below and choose the one that best describes your own situation. **This scale focuses mainly on how well you walk.** You might not find a description that reflects your condition exactly, but please mark the **ONE** category that describes your situation the closest.

☐ 0 I may have some mild symptoms, mostly sensory due to MS/neurologic condition but they do not limit my activity. If I do have an attack, I return to normal when the attack has passed.

☐ 1 I have some noticeable symptoms from my MS/neurologic condition, but they are minor and have only a small effect on my lifestyle.

☐ 2 I do not have any limitations in my walking ability. However, I do have significant problems due to my MS/neurologic condition that limit daily activities in other ways.

☐ 3 My MS/neurologic condition does interfere with my activities, especially my walking. I can work a full day, but athletic or physically demanding activities are more difficult than they used to be. I usually do not need a cane or other assistance to walk, but I might need some assistance during an attack.

☐ 4 I use a cane or a single crutch or some other form of support (such as touching a wall or leaning on someone's arm) for walking all the time or part of the time, especially when walking outside. I think I can walk 25 feet in 20 seconds without a cane or crutch. I always need some assistance (cane or crutch) if I want to walk as far as 3 blocks.

☐ 5 To be able to walk 25 feet, I have to have a cane, crutch, or someone to hold onto. I can get around the house or other buildings by holding onto furniture or touching the walls for support. I may use a scooter or wheelchair if I want to go greater distances.

☐ 6 To be able to walk as far as 25 feet I must have 2 canes or crutches or a walker. I may use a scooter or wheelchair for longer distances.

☐ 7 My main form of mobility is a wheelchair. I may be able to stand and/or take one or two steps, but I cannot walk 25 feet, even with crutches or a walker.

☐ 8 Unable to sit in a wheelchair for more than one hour.

MSRS-R Assessment of Your Current Functioning

Please circle the number under the description that best matches your symptoms for each activity in the far-left column. You might not find a description that reflects your condition exactly, but please circle the **ONE** category that describes your situation the closest.

ACTIVITY	"I have no symptoms or disability in this specific area"	"I am aware of symptoms but no limits on my activities"	"I have mild limits on my activities, but I do not need help from others or to use other aides"	"I have moderate limits on my activities, and I sometimes need help from others or use other aides"	"I have severe limits on my activities, and I usually need help from others or use other aides"
Walking	**0**	**1**	**2**	**3**	**4**
Using your arms and hands	**0**	**1**	**2**	**3**	**4**
Vision	**0**	**1**	**2**	**3**	**4**
Speech	**0**	**1**	**2**	**3**	**4**
Swallowing	**0**	**1**	**2**	**3**	**4**
Thinking, memory, or cognition	**0**	**1**	**2**	**3**	**4**
Numbness, tingling, burning sensation or pain	**0**	**1**	**2**	**3**	**4**
Controlling your bladder and/or bowel	**0**	**1**	**2**	**3**	**4**