Multiple Sclerosis Treatment Center of Dallas
Annette Okai, MD
NEW PATIENT INFORMATION

Today's Date: _____ Age _____ Gender: [ ] M [ ] F

Patient Name: _____ Date of Birth: _____

Please indicate the name and relationship to the patient of the person completing this form (if not patient):
Name _____ Relationship to patient: _____

Referring Physician:	
Address:	
City, State, ZIP:	
Office Telephone:	
Office Fax:	

Primary Care Physician:	
Address:	
City, State, ZIP:	
Office Telephone:	
Office Fax:	

Have you ever been evaluated for these problems elsewhere?

Date	Physician/Hospital	Phone #	Diagnosis
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Dominant hand: [ ] Right [ ] Left [ ] Ambidextrous

When did you first begin to experiencing symptoms? _____

List the most prominent symptoms at time of onset:

1._____ 4._____
2._____ 5._____
3._____ 6._____

Were you ill with fever, chills or infection at the time of your symptoms began?
[ ] Yes [ ] No Explain:_____

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Rate yourself in each of the following potential problem areas. In each case, check the circle next to the number that describes your condition:

A. **VISION**
[ ] 0 No complaints
[ ] 1 Occasional difficulty focusing or fixating when under stress or looking at rapidly changing images.
[ ] 2 Occasional difficulty fixating or focusing in everyday situations.
[ ] 3 Cannot read but otherwise vision good enough for everyday life.
[ ] 4 Severe problems with focusing or moving images.
[ ] 5 Focusing or fixation difficulties so great that there are always severe problems.

B. **CLUMSINESS of HANDS**
[ ] 0 No complaints.
[ ] 1 Minor change in handwriting.
[ ] 2 Occasional fumbling with ordinary activities.
[ ] 3 Frequent fumbling causing difficulty with eating, dressing, writing or working but you still do these things routinely.
[ ] 4 Severe fumbling, causing many tasks to be avoided entirely.
[ ] 5 Hands are essentially useless.

C. **WALKING and BALANCE**
[ ] 0 No complaints
[ ] 1 Diminished coordination in athletics or extraordinary activities.
[ ] 2 Occasional stumbling or slipping in everyday activities.
[ ] 3 Frequent falls unless a cane is used.
[ ] 4 Frequent falls unless a walker or fixed supporting object is used.
[ ] 5 Confined to a wheelchair.

D. **BLADDER FUNCTION**
[ ] 0 No complaints
[ ] 1 Occasional urgency but no episodes of incontinence, no infections.
[ ] 2 Frequent urgency with occasional accidents and change in daily routine.
[ ] 3 Urgency and retention with need for intermittent self-catheterization.
[ ] 4 Urgency and retention with need for intermittent self-catheterization.
[ ] 5 Urinary incontinence.

E. **FATIGUE**
[ ] 0 No complaints
[ ] 1 Exercise tolerance not as great as before, but everyday activities do not produce unusual fatigue.
[ ] 2 Everyday activities cause fatigue but daily routine not changed.
[ ] 3 Daily activities cause enough fatigue to cause schedule changes.
[ ] 4 Daily activities cause severe fatigue such as that some everyday activities have been eliminated.
[ ] 5 Essentially confined to movement from bed or chair.

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For each affected area, please indicate the level of severity for each part of the body.
1. =not bothered 2. =mildly bothered 3. =moderately bothered 4. =quite a bit bothered 5. =severe bothered

	Left	**Right**
Numbness Tingling	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Weakness, loss of Power / strength	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Spasms, muscles, cramps, stiffness	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Pain, burning, increased sensitivity	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Tremors, shakes, jerks	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Face [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Trunk [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Problem with coordination	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Arm [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5	Leg [ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Difficulty walking	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Blurred/loss vision	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Problem with color vision	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Double vision	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Eye pain	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Hearing loss	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Ringing in ears	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Difficulty speaking/slurred	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Difficulty chewing/drinking/swallowing	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Dizziness, vertigo, balance	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Difficulty thinking, remembering, concentrating	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Pain or shock like sensation when bending neck	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5
Headaches	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5	[ ]1 [ ]2 [ ]3 [ ]4 [ ]5

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Please check the symptoms you are experiencing or have experienced over the past THREE months: (Review of Systems)

- O Heat/Cold Tolerance
- O Sweating
- O Increased thirst
- O Increased urination
- O Unexplainable Weight gain/loss >10lbs
- O Frequent sore throat
- O Skin problem/chronic (particularly face)
- O Recurrent oral/genital sores/ulcers
- O Take medication to prevent recurrent sores/ulcers
- O Sores/ulcers on other parts of body
- O Chest pain/pressure
- O Palpitations/irregular heartbeat
- O Wheezing
- O Cough, chronic, productive
- O Swelling, Feet, legs
- O Burning on urination
- O Change in bladder habits
- O Urination at night
- O Frequent Urination
- O Urine incontinence/leakage
- O Blood in urine/flank pain
- O Anxiety/mood swings
- O Depression
- O Hallucination/delusions
- O Muscle pains/aches
- O Joint pain/stiffness
- O Joint inflammation/swelling
- O Neck/back pain
- O Spine or disc disease
- O Easy bruising/bleeding tendency
- O Unusual bleeding
- O Fever
- O Tumor/Change in mole
- O Cancer
- O Lesions which have been biopsied
- O Swollen lymph nodes/glands
- O Loss of sexual desire
- O Difficulty achieving orgasm
- O Difficulty sustaining erection
- O Menstrual problems
- O Decreased appetite
- O Change in bowel habits
- O Nausea/vomiting
- O Diarrhea
- O constipation
- O Bowel incontinence/leakage
- O Blood in bowel movements
- O Abdominal Pain/frequent
- O Sleep problems
- O Fatigue
- O Other _____

For women:

[ ] I am pregnant: ____ Months pregnant
[ ] I could possibly be pregnant
[ ] I have had complications of pregnancy
Are you menopausal / premenopausal?
[ ] Yes [ ] No
Number of confirmed pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Age at onset menses: _____
Date of first live birth: _____
Method of birth control:
[ ] Birth control pills
[ ] Condoms
[ ] Diaphragm
[ ] Tubal ligation/vasectomy/hysterectomy
[ ] Other _____

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Date of Last Brain MRI _____ Results: [ ] Normal [ ] Abnormal
Supportive of MS Diagnosis? [ ] Yes [ ] No [ ] Test inconclusive

Date of last Spinal Cord MRI_____ Results: [ ] Normal [ ] Abnormal
Supportive of MS Diagnosis? [ ] Yes [ ] No [ ] Test inconclusive

Date of last Cerebrospinal Fluid Results (spinal tap) _____ Results: [ ] Normal [ ] Abnormal

Are CSF results supportive of MS Diagnosis? [ ] Yes [ ] No [ ] Test inconclusive

Test	Dates	Results
Evoked Potentials		
Visual, Auditory Somatosensory		
Blood Tests		
Lyme, B12, Folate, Thyroid, HIV		
Arthritis, Hepatitis, Sarcoid		
Neuropsychological testing		

Indicate the types of **MS therapies** you have received in the past or are presently receiving: (choose all that apply). Also indicate the number of months you have received the therapy, combing past present use (ex. If you were taking therapy for 3 months, had a break in treatment and now have been taking the therapy for 6 months, total duration of use is 9 months).

Therapy	Duration of use (months)	Past use	Present use
Avonex (Interferon beta-1a, IM)			
Betaseron (Interferon beta 1b)			
Copaxone (Glatiramer acetate)			
Rebif (Interferon beta 1a)			
Extavia (Interferon beta 1b)			
Novantrone (Mitoxantrone)			
Tysabri (Natalizumab)			
Gilenya (Fingolimod)			
Aubagio (Teriflunomide)			
Tecfidera (Dimethyl Fumarate)			
Plegridy (Interferon beta-1a, SC)			
Lemtrada (Alemtuzumab (Campath,)			
Ocrevus (Ocrelizumab)			
Zinbryta (Daclizumab)			
Cytoxan (Cyclophosphamide)			
Rituxan (Rituximab)			
Cellcept (mycophenolate)			
Folex (Methotrexate)			
Imuran (Azathioprine)			
IVIg (Intravenous Immunoglobulin)			
Steroids (Prednisone, Solumedrol, ACTH)			
[ ] For exacerbation only			
[ ] Regular monthly pulse dose			
[ ] Both exacerbations and pulse dose			

Past Medical History:

Prenatal

Was your mother's pregnancy with you abnormal? [ ] Yes [ ] No If yes, explain: _____
Was your birth [ ] vaginal or [ ] cesarean
Were there any complications at your birth? [ ] Yes [ ] No If yes, explain: _____
Are you a twin? [ ] Yes [ ] No Fraternal or identical: _____

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Infancy/Childhood

Vaccinations	Yes	No	Approximate Age/Year
Mumps/Measles/Rubella			
BCG (against TB)			
Hepatitis B			
Pertussis			
Other			

Did you have any problems after birth, during infancy or childhood such as:

- O High Fevers
- O Meningitis
- O Transverse Myelitis
- O Encephalitis
- O Head Injury – severe
- O Seizures/epilepsy
- O Stroke
- O Optic neuritis Before age 18

Infectious Exposures	Yes	No	Approximate Age/Year
Mumps			
Measles			
Rubella			

Please check the illness/medical problem you currently have or have had in the past:

- O Cataracts
- O Glaucoma
- O Uveitis
- O Optic Neuritis
- O Sleep Apnea
- O Headaches
- O Migraines
- O Stroke/brain bleed/ mini stroke/TIA
- O Seizure/epilepsy
- O High blood pressure
- O High cholesterol
- O Heart murmur
- O Heart attack
- O Congestive heart failure
- O Asthma
- O Anemia (Low blood count)
- O Blood clot (leg/lung)
- O Stomach ulcer
- O Liver disease
- O Hepatitis A
- O Hepatitis B
- O Hepatitis C
- O Kidney disease
- O Prostate disease
- O Tuberculosis TB
- O Lyme Disease (tick bite)
- O AIDS/HIV
- O Syphilis
- O Other sexually transmitted diseases
- O Cancer
- O Lymphoma
- O Leukemia
- O Tumors
- O Anxiety
- O Depression
- O suicidal thoughts
- O Psychosis
- O Psychiatric problem/other
- O Degenerative disc disease
- O Osteoarthritis
- O Thyroid disorder
- O Vitamin B-12 deficiency
- O Myasthenia gravis
- O Sjogrens syndrome
- O Sarcoidosis
- O Allergies
- O Lupus erythematosus SLE
- O Rheumatoid arthritis
- O Vasculitis
- O Psoriasis
- O Crohn's disease
- O Diabetes Mellitus I / II

Other Medical Problems:

_____

_____

Past Surgical History*: Include Spine, joint, bone, cardiac, (including pacemakers) and cancer surgery:*

Surgery/Operation	Year	Injuries (motor vehicle, loss of consciousness, head trauma, fractures)

Current Medications*:*

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Hormone Therapies:

	Hormone Therapy	Dosage	Frequency (times/day)	Duration of use (months)
	Estrogen: Premarin			
	Oral Contraceptives: e.g. Ortho Novum			
	Progesterone:			
	Non Steroidal anti-inflammatory			
	NSAID: Advil, Motrin			

Vitamins/Herbal Preparation/Complementary therapies/Social diets (please list)

	Name	Dosage	Frequency (times/day)	Duration of use (months)

Please list all ALLERGIES to medication and the REACTION you had to them. Include dyes, contrast agents, iodine or shellfish.

MEDICATION ALLERGY	REACTION TO MEDICATION

SOCIAL HISTORY

Marital Status:
[ ] Single [ ] Married [ ] Cohabitating [ ] Separated [ ] Divorced [ ] Widowed

Spouse/Partner's Name: _____

Do you have children? [ ] Yes [ ] No Number of children: _____

Do you wish to have child/more children in the future? [ ] Yes [ ] No

Do you have a caregiver? [ ] Yes [ ] No

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Place of birth: _____ State: _____ Country:_____

Place of residence for the majority of your first 15 years of life (state & county):_____

Do you currently smoke cigarettes? [ ] Yes [ ] No Have you ever smoked cigarettes? [ ] Yes [ ] No

Do you currently drink alcohol? [ ] Yes [ ] No Number of drinks per week: _____

Did you ever drink alcohol in quantity or counseled to stop drinking? [ ] Yes [ ] No

Have you ever used recreational drugs, or been in treatment for their use? [ ] Yes [ ] No

Race:

- O Caucasian
- O Black / African American
- O Asian/Pacific Islander
- O American Indian/Alaskan
- O Hispanic
- O Other

Education:

- O Less than 12 years
- O High school graduate
- O 1-3 years of college or technical school
- O College or technical school graduate
- O Post graduate education

Current Employment:

- O Employed
- O Sheltered
- O Cannot find work
- O Disabled, age <60
- O Retired not disabled age <60
- O Retired age 60+
- O Homebound employment
- O Volunteer
- O Student
- O Worker's comp.
- O Homemaker
- O Unemployed

Occupation:_____

Employer:_____

Has your disease affected your job or work activity?

- O I have never been able to work
- O I have been only been able to work part time
- O It has interfered with or caused me to miss work
- O I have applied for (circle one): short term disability, long term disability, social security disability
- O I was rejected for disability because _____
- O I am awaiting a determination for disability
- O I changed jobs because of the disease
- O I lost jobs because of the disease
- O No change has occurred due to the disease
- O I had already stopped working by the time the disease started

Please indicate your present living situation; indicate those who live with you at the present time:

- O Spouse/partner
- O Children
- O Parents

O No one O Friends O Other relatives

Indicate the type of residence in which you currently reside:

O Private residence O Apartment O Nursing home O Other type facility

Is your residence accessible by a wheelchair? [ ] Yes [ ] No

Are you currently in counseling / psychotherapy? [ ] Yes [ ] No
If yes, please provide:
Therapist Name:_____
Address:_____
Telephone Number:_____

Permission to contact therapist if necessary? [ ] Yes [ ] No

FAMILY HISTORY

O Multiple sclerosis
O Seizures
O Stroke TIA
O Brain Tumors
O Brain Aneurysm
O Movement Disorders
O Myasthenia gravis
O Systemic lupus erythematosus (SLE)
O Psoriasis
O Rheumatoid Arthritis
O Allergies
O Cardiac disease
O Blood disorders
O Cancer
O Sjogrens disease
O Scleroderma
O Crohn's
O Thyroiditis
O Juvenile diabetes mellitus
O Manic depressive illness
O High blood pressure

Relationship	Deceased	Living	Neurological/Medical Problems or Cancer	Country of birth
Father's Father				
Father's Mother				
Father's Brother				
Father's Sisters				
Father				
Mother's Father				
Mother's Mother				
Mother's Brothers				
Mother's Sisters				
Mother				
Brothers				
Sisters				
Sons				
Daughters				

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How did you learn about the Center?

_____

_____

Thank you for taking the time to provide the information above.

Patient / Patient's representative signature: _____