UCSF MULTIPLE SCLEROSIS CENTER INTAKE SHEET

400 Parnassus Ave – 8th floor, San Francisco, CA 94143
Tel: 415-353-2069 Fax:415-353-2633

Checklist of important records *Note: If you have not had a particular test (other than the brain MRI) it is not necessary to have it prior to your appointment*	☐ MRI Films *(Please bring with you the day of appointment)* ☐ MRI Reports ☐ Lumbar Puncture Results ☐ Visual Evoked Potential ☐ Any Nerve Conduction Studies ☐ EEG ☐ Lab Work	☐ Copies of insurance Card *(Front & Back)* ☐ Authorization for appointment *(If needed)* ☐ List of Medications/any allergies *(If known)*	☐ History & Physical ☐ Treatment Summary ☐ Any Dictations from Any MD seen regarding your condition *(within year)*

Section	Field		Field	
CONTACT INFORMATION	**Name** *(Last/First/Middle)*		**Date of Birth**	
	Maiden Name		**SS #**	
	Address **City, State, Zip**		**Sex** **Marital Status**	
	Home phone #		**Race/Ethnicity**	
	Cell phone #		**Religion**	
	Home Fax #		**Email**	
	Employer		**Occupation**	
	Work Phone		**Employment Status**	
	Emergency Contact		**Relationship**	
	Address		**Phone**	
	Additional Contacts		**Relationship**	
INSURANCE INFORMATION	**Primary Insurance** *Will need medical group name if policy is an HMO*		**Subscriber** *Will need subscriber's DOB and SS# if not the pt*	
	Note – if the patient has Medicare/Medi CAL...	*- is it managed by another policy/HMO?*	**Phone #** **Fax #**	
	Subscriber ID #		**Group #**	
	Mailing Address *(usually a PO Box#)*		**Effective date** *(if known)*	
	Secondary Insurance *Will need medical group name if policy is an HMO*		**Subscriber** *Will need subscriber's DOB and SS# if not the pt*	
	Note – if the patient has Medicare/Medi CAL...	*- is it managed by another policy/HMO?*	**Phone #** **Fax #**	
	Subscriber ID #		**Group #**	
	Mailing Address *(usually a PO Box#)*		**Effective date** *(if known)*	
MEDICAL INFORMATION	**Referring MD**		**Specialty**	
	Address **City, State, Zip**		**Phone #** **Fax #**	
	Primary MD		**Specialty**	
	Address **City, State, Zip**		**Phone #** **Fax #**	
	Additional Providers		**Specialty**	
	Address **City, State, Zip**		**Phone #** **Fax #**	

UCSF Multiple Sclerosis Center

Intake Form for Patients Already Diagnosed with Multiple Sclerosis (MS)

Name: ______________________________

Please list all of your current and past medical problems:

Medical Problem	Year of Onset	Medical Problem	Year of Onset

Please list any surgery you have had:

Surgery	Date	Surgery	Date

List your current medications and supplements:

Medication or Supplement Name	Dose/how often	Why are you taking this medication?

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Please list any allergies or intolerances to medications or to contrast dye (CT or MRI):

Medication	Reaction	Medication	Reaction

Does anyone in your family have multiple sclerosis or an autoimmune disease? If so, who?

Please list any other health problems that occur in your family and which family members are affected:

How would you describe your race:

☐White, non-Hispanic ☐African American ☐Native American

☐White, Hispanic ☐Asian ☐Other: ______________________

Are you: ☐married ☐single ☐divorced ☐widowed ☐living with partner

Are you able to work?: ☐not able to work ☐part-time ☐full-time Occupation? ____________

Do you smoke cigarettes?: never former smoker current smoker

If you are or were a smoker, when did you start (and stop, if applicable)?

If you are or were a smoker, how many packs per day did you smoke through the years?

How often do you drink alcohol? never rarely occasionally often daily

Please describe any illicit drug use (when, frequency, amount, duration of use):

Do you currently/have you recently experienced the following? Please check:

☐Unexplained weight loss ☐Cough ☐Trouble swallowing

☐Fever or night sweats ☐Shortness of breath ☐Abdominal pain

☐Swollen glands ☐Chest pain or pressure ☐Nausea/vomiting

☐Skin rash ☐Swelling of the legs ☐Diarrhea/constipation

☐Joint pain ☐Joint swelling ☐Bloody stools

☐Recent easy bruising ☐Genital or mouth ulcers ☐Frequent urinary infections

☐Sore throat or ear pain ☐Anxiety ☐Depression

What is your current height? __________ What is your current weight? __________

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Name: ________________________________

Have you ever been told by a doctor that you have the following diagnosis?:

☐HIV/AIDS
☐Stroke
☐Hypertension (high blood pressure)
☐Meningitis
☐Sjogren's disease
☐Seizure or epilepsy
☐Heart attack
☐Thyroid disease
☐Diabetes
☐Tuberculosis
☐Lupus
☐Hepatitis
☐Other heart condition
☐Cancer
☐Muscle disease
☐Syphilis
☐Rheumatoid arthritis

Please describe the type of multiple sclerosis with which you have been diagnosed:

☐Clinically isolated syndrome
☐Relapsing-remitting multiple sclerosis
☐Secondary progressive multiple sclerosis
☐Primary-progressive multiple sclerosis
☐Progressive-relapsing multiple sclerosis

When did the symptoms of MS start (year)? _____ When were you diagnosed with MS (year)? _____

Please describe what the MS has been like for you:

☐I have attacks in which I am worse for a period of time (at least 24 hours), followed by improvement in my condition (complete or incomplete). In between the attacks I am stable.
☐I am having attacks, but in between the attacks I am also getting progressively worse.
☐My disease began with attacks but subsequently changed so that now I have been getting progressively worse and no longer have discrete attacks.
☐My disease began with attacks but subsequently changed so that now I have been getting progressively worse, although I still have occasional attacks.
☐From the start, my disease has gotten steadily and progressively worse; I have never had an attack.
☐From the start, my disease has gotten steadily/progressively worse, but I have had occasional attacks.

If you have had attacks of MS, please describe them in chronological order. Attacks are new/recurrent symptoms lasting at least 24 hours in the absence of an infection/fever:

Month/year it occurred	Symptoms During Attack	Duration of attack	Treated with steroids?	Did the symptoms resolve completely?

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Name: ___________________________________

Which of the following best describes you?

☐I am able to carry out my usual daily activities without limitation

☐I have limitations but can carry out most of my usual daily activities, even if I may require some special provisions such as altered work hours or naps.

☐I am able to carry out about only half of my usual daily activities even with special provisions.

☐I am severely limited in my ability to carry out my usual daily activities.

☐I need assistance with my self-care activities (dressing, bathing, transferring, going to the bathroom).

Have you had EVER experienced the following symptoms?

☐Visual loss (not corrected with glasses/contacts)? If so, was it in the: ☐right eye ☐left eye ☐both eyes

☐Double vision

☐Weakness (loss of strength)? If so, was it in the: ☐right arm ☐right leg ☐left arm ☐left leg

☐Muscle twitching or cramping, or loss of muscle bulk

☐Changes in sensation? If so, was it in the: ☐right arm ☐right leg ☐left arm ☐left leg

☐Incoordination? If so, was it in the: ☐right arm ☐right leg ☐left arm ☐left leg

☐Loss of balance or trouble walking?

☐Problems with the bladder, bowels, or sexual function?

☐Changes in your emotions?

☐Problems with thinking or memory?

☐Brief (1 to 2 minutes) spasms in an arm or leg? (often several per day)?

☐Brief (1 to 2 minutes) episodes of slurred speech and poor balance (often several per day)?

☐Electrical shock-like sensation when you bend your neck down (not general neck pain)?

☐Pain? If so, where ____

☐Symptoms that worsen with heat or exercise?

Please check the box corresponding to any CURRENT symptoms (not those that have resolved):

Strength

	Normal	Mildly weak	Moderately weak	Severely weak
Right arm	☐	☐	☐	☐
Right leg	☐	☐	☐	☐
Left arm	☐	☐	☐	☐
Left leg	☐	☐	☐	☐
Face	☐	☐	☐	☐

Spasticity/Spasms

	None	Mild	Moderate	Severe
Right arm	☐	☐	☐	☐
Right leg	☐	☐	☐	☐
Left arm	☐	☐	☐	☐
Left leg	☐	☐	☐	☐

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Name: ______________________________

Sensation/Feeling

	Normal	Mildly abnormal	Moderately abnormal	Severely abnormal
Right arm	☐	☐	☐	☐
Right leg	☐	☐	☐	☐
Left arm	☐	☐	☐	☐
Left leg	☐	☐	☐	☐
Face	☐	☐	☐	☐

Coordination

	Normal	Mildly abnormal	Moderately abnormal	Severely abnormal
Right arm	☐	☐	☐	☐
Right leg	☐	☐	☐	☐
Left arm	☐	☐	☐	☐
Left leg	☐	☐	☐	☐

Vision (while using glasses or contacts if you have them)

	Normal	Mildly abnormal	Moderately abnormal	Severely abnormal
Right eye	☐	☐	☐	☐
Left eye	☐	☐	☐	☐

How often have the following symptoms occurred in the past year:

	Never	Occasionally	Frequently	All/almost all the time
Double vision	☐	☐	☐	☐
Imbalance	☐	☐	☐	☐
Trouble swallowing	☐	☐	☐	☐
Slurred speech	☐	☐	☐	☐
Vertigo/spinning	☐	☐	☐	☐
Depressed mood	☐	☐	☐	☐
Trouble thinking	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐
Sexual dysfunction	☐	☐	☐	☐

Bladder and Bowel

	Normal	Mildly abnormal*	Incontinent **	Catheterization***
Bladder	☐	☐	☐	☐
Bowel	☐	☐	☐	☐

*If your bladder is mildly abnormal, do you have:

☐ Frequency (I have to go unusually often)

☐ Urgency (I have to go quickly once I get the urge)

☐ Hesitancy (I have trouble getting started)

** If you are incontinent, is it:

☐Occasional (less than once per week)

☐Frequent (not daily, but several times per week)

☐Often (at least once a day)

***If you use self-catheterization, do you do it:

☐Less than once a day

☐At least once at day

☐I have an indwelling catheter

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Over the past 2 weeks, how often have you been bothered by any of the following problems?	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

Which of the following best describes your ability to walk?

☐I can walk without any problem.
☐I have some difficulty with walking, but I can walk without aid for at least 500 meters (1/3 mile, or the length of five football fields).
☐I have some difficulties with walking, but I can walk without aid for about 300 meters (1/5 mile, or the length of 3 football fields).
☐ I have some difficulties with walking, but I can walk without aid for about 200 meters (1/10 mile, or the length of 2 football fields).
☐ I have some difficulties with walking, but I can walk without aid for about 100 meters (300 feet).
☐I require an aid (cane, crutch, walker, or another person) to walk 100 meters (300 feet).
☐I require an aid (cane, crutch, walker, or another person) to walk 20 meters (60 feet).
☐I require an aid (cane, crutch, walker, or another person) to walk 8 meters (25 feet).
☐I use a wheelchair for almost all activities.
☐I am confined to bed most of the time.

When you move about, what percentage (0% to 100%) of the time do you:

Walk without aid?_________
Use a cane, single crutch, or hold onto another person?__________
Use a walker or support on both sides? __________
Use a wheelchair?__________

Do you experience worsening of any of your symptoms in the heat or when you are tired, sick, or stressed? ☐No ☐Yes, of the following symptoms: ______________________________________
____

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Which of the following have you received as a routine treatment for MS?

Medication	Date started	Date stopped	Reason for stopping
Avonex (interferon beta-1a)			
Betaseron (interferon beta-1b)			
Rebif (interferon beta-1a)			
Copaxone (glatiramer acetate)			
Tysabri (natalizumab)			
Rituxan (rituximab)			
Cytoxan (cyclophosphamide)			
Novantrone (mitoxantrone)			
Cellcept (mycophenolate mofetil)			
Sandimmune (cyclosporine)			
Imuran (azathioprine)			
Leustatin (cladribine)			
Solumedrol (methylprednisolone)			
Decadron (dexamethasone)			
Prednisone			
Plasma exchange/pheresis			
Intravenous immunoglobulin (IVIg)			

Please describe in 2 to 3 sentences why you are here:

Please write the name and address of any physicians to whom you would like us to send a report: