

KC Multiple Sclerosis Center
College Park Family Care Center - Neurology
10600 Mastin, Overland Park KS, 66212

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MS and NMO Program

Established MS New Patient Questionnaire

Dear Patient:

Thank you for choosing KC MS Center with College Park Family Care Center's Neurology Clinic for your care. We are looking forward to your visit here.

We respect your time and we would like to make your visit to our office as efficient as possible. Please submit the following documents immediately for review by one of our MS specialists.

Please submit the following:

- Completed **Medical Questionnaire** (Questionnaire attached)
- A **Referral Letter** from your current Neurologist or Primary Care Physician
- please locate and organize the attached required outline of Medical records behind the attached summary page:**
 - Initial consult note from Neurologist
 - All Imaging reports
 - Lumbar Puncture results
 - VEP
 - SSEP
 - Neuroophthamology/OCT Report and Consultation
 - Recent labs (last 6 months)
 - Most recent JCV status lab work
 - Any Vascular disease work up medical documentation such as:
 - Hypercoagulable profile
 - Carotid Doppler
 - Echocardiogram
 - Stress nuclear testing
 - MRA brain/MRA Neck
- Please provide remaining Medical Records from Neurologist separate from above**
- CD / Films** from Brain / Spine MRI, CT, etc. **must** be brought to initial visit or can be delivered to clinic prior to visit.

You may return the documents by fax to (913) 438-2813, attention MS Center New Patient Coordinator or you may submit them by mail. Please bring your MRI films, referral authorization form (if applicable), insurance card(s), and photo identification with you to your appointment.

If you would like to submit your documents by mail, please mail them to:

College Park Specialty Center
Entrance C
10600 Mastin Overland Park, KS 6612

You may also hand deliver your documents by stopping by our neurology suite located at entrance C of the specialty clinic.

The information you provide will be reviewed by an MS Specialist. If it is determined that you are an appropriate candidate for the clinic you will be contacted by a scheduler, at which time an appointment date and time will be provided. If the MS Specialist finds that your needs are better met by another physician, we will be pleased to further assist you with your referral according to the recommendations.

If you have any questions or concerns please contact us at (913) 438-0868. Thank you again for choosing us to participate in your care.

Sincerely,
Department of Neurology

Enc.: New Patient Questionnaire, New Patient Outline

PATIENT QUESTIONNAIRE

Multiple Sclerosis Program

*PATIENT QUESTIONNAIRE MUST BE COMPLETED AND RETURNED
WITH MEDICAL RECORDS PRIOR TO SCHEDULING TO:*

COLLEGE PARK FAMILY CARE CENTER, NEUROLOGY

MS PROGRAM

ATTN: REFERRALS COORDINATOR

**10600 Mastin – Entrance C
Overland Park, Kansas 66212**

Phone: (913) 438-0868 • Fax: (913)-438-2813

The Neurology Clinic is located in the back of the building through entrance C.

NAME: _____ AGE: _____ DATE: _____
Sex: M F

ADDRESS: _____

HOME PHONE NUMBER: _____ DATE OF BIRTH _____

WORK PHONE NUMBER: _____

USUAL PHARMACY NAME: _____ TELEPHONE: _____

ARE YOU: LEFT HANDED OR RIGHT HANDED

PRESENT OCCUPATION: _____ PRIOR OCCUPATIONS: _____

HOURS WORKED PER WEEK: _____ EDUCATION COMPLETED: _____

IF YOU ARE DISABLED FROM WORK, WHEN DID YOU BECOME DISABLED? _____

WITH WHOM DO YOU LIVE? _____

ARE YOU Single Married Divorced Widowed

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.

Describe your major problem or the reason why you are seeing us.

Exactly when did your problem begin? Please describe in detail the circumstances in which the problem began and what were your initial symptoms and problems. What might have caused the problem to begin? (Stress? Accident?) Chronologically detail the problems you have experienced. Please include details concerning the **diagnostic tests** and **treatments that you have received** and **your response to these**.

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

What do you personally think your problem is due to?

Have you ever received any of the following medications? If so, what was the result? Have you tested for antibodies against Interferon?

Yes	Medicine	When?	Result
<input type="checkbox"/>	BetaSeron		
<input type="checkbox"/>	Have you tested for antibodies against Interferon	_____	_____
<input type="checkbox"/>	Avonex		
<input type="checkbox"/>	Have you tested for antibodies against Interferon	_____	_____
<input type="checkbox"/>	Extavia		
<input type="checkbox"/>	Have you tested for antibodies against Interferon	_____	_____
<input type="checkbox"/>	Rebif		
<input type="checkbox"/>	Have you tested for antibodies against Interferon	_____	_____
<input type="checkbox"/>	Copaxone	_____	_____
<input type="checkbox"/>	IV Steroids	_____	_____
<input type="checkbox"/>	Oral Steroids	_____	_____
<input type="checkbox"/>	Cytosan	_____	_____
<input type="checkbox"/>	Methotrexate	_____	_____
<input type="checkbox"/>	IVIG	_____	_____
<input type="checkbox"/>	Azathioprine (Imuran)		

<input type="checkbox"/>	Mycophenolate/Myfortic Acid (Cellcept)	_____	_____
<input type="checkbox"/>	Natalizumab (Tysabri) Tested against antibodies? Tested for JC Virus IgG Antibody?	<input type="checkbox"/> <input type="checkbox"/>	_____
<input type="checkbox"/>	Rituninab (Rituxan)	_____	_____
<input type="checkbox"/>	Fingolimod/FTY-720 (Gilenya)	_____	_____
<input type="checkbox"/>	Plasma exchange/plasma pheresis	_____	_____
<input type="checkbox"/>	Mitoxantrone (Novantrone)	_____	_____
<input type="checkbox"/>	IV Methotrexate	_____	_____
<input type="checkbox"/>	4-aminopyridine (4-AP) (compound or Ampyra)	_____	_____
<input type="checkbox"/>	Experimental agents	_____	_____
<input type="checkbox"/>	Stem Cell Treatment? Where?	_____	_____
<input type="checkbox"/>	CCSVI Treatment? (chronic cerebrospinal venous insufficiency) Where and When?	_____	_____
<input type="checkbox"/>	Other MS Medicine	_____	_____
<input type="checkbox"/>		_____	_____

**Are you interested in learning about opportunities to participate in clinical research trials?
Yes/No**

Have you participated in clinical trials? Please list and provide dates.

Please give **DETAILS** for all yes answers

1. NEUROLOGIC HISTORY

YES

WHEN?

IS IT ONGOING

- | | | | |
|--------------------------|--|-------|-------|
| <input type="checkbox"/> | Trouble with walking | _____ | _____ |
| <input type="checkbox"/> | Weakness in part of your body (where) | _____ | _____ |
| <input type="checkbox"/> | Trouble with balance | _____ | _____ |
| <input type="checkbox"/> | Any falls? | _____ | _____ |
| <input type="checkbox"/> | Do you use any of the following? | | |
| <input type="checkbox"/> | Leg Braces (AFO) | _____ | _____ |
| <input type="checkbox"/> | Cane | _____ | _____ |
| <input type="checkbox"/> | Crutches | _____ | _____ |
| <input type="checkbox"/> | Walker | _____ | _____ |
| <input type="checkbox"/> | Standard wheelchair | _____ | _____ |
| <input type="checkbox"/> | Electric Wheelchair | _____ | _____ |
| <input type="checkbox"/> | Scooter | _____ | _____ |
| <input type="checkbox"/> | Impaired vision | _____ | _____ |
| <input type="checkbox"/> | Double vision | _____ | _____ |
| <input type="checkbox"/> | Blurred vision | _____ | _____ |
| <input type="checkbox"/> | Flashes of light | _____ | _____ |
| <input type="checkbox"/> | Jumping of vision, for example when walking or riding | _____ | _____ |
| <input type="checkbox"/> | Trouble reading | _____ | _____ |
| <input type="checkbox"/> | Electric type shocky sensations with neck flexation or handwriting | _____ | _____ |
| <input type="checkbox"/> | Symptoms made worse by heat | _____ | _____ |
| <input type="checkbox"/> | Problems with speech | _____ | _____ |
| <input type="checkbox"/> | Problems with memory | _____ | _____ |
| <input type="checkbox"/> | Seizures | _____ | _____ |
| <input type="checkbox"/> | Dry eyes or dry mouth | _____ | _____ |
| <input type="checkbox"/> | Face pain | _____ | _____ |
| <input type="checkbox"/> | Difficulty Swallowing | _____ | _____ |
| <input type="checkbox"/> | Numbness or pins/needles in part of your body (where) | _____ | _____ |
| <input type="checkbox"/> | Changes in your energy level | _____ | _____ |
| <input type="checkbox"/> | Cramps/Spasms limbs | _____ | _____ |
| <input type="checkbox"/> | Tightness/stiffness limbs | _____ | _____ |
| <input type="checkbox"/> | Limitations of activity due to above | _____ | _____ |
| <input type="checkbox"/> | Pain due to above | _____ | _____ |
| <input type="checkbox"/> | Diarrhea or constipation | _____ | _____ |

Bladder problems

- How many times do you normally urinate during the day _____
- How many times do you normally get up at night to urinate _____
- Have you ever lost control of your bladder? _____

Do you get strong urges to urinate?

Do you ever have difficulty starting to urinate?

Do you feel like you completely empty your bladder?

Have you had bladder/urine infection (when)?

1. NEUROLOGIC HISTORY CONTINUED

WHEN?

IS IT ONGOING

YES

- Have you had bladder or kidney stones (when)?
- Problems with sexual function –interest in sex, sensation, arousal, erection, ejaculation, arousal, lubrication, orgasm?

2. Dizziness and Imbalance - If you do not have a problem with dizziness or imbalance go to the next section. Have you ever experienced the following?

WHEN?

IS IT ONGOING

YES

- Sense of motion of the environment
- Sense of motion of your own body
- Spinning inside of your head
- Sensation of tilt, pulling or rotation/spinning (which way)
- Rocking
- Lightheadedness or fainting
- Fear or avoidance of being in public places
- Sweating
- Nausea, vomiting
- Jiggling eye movements

To what extent is your dizziness or imbalance affected or brought on by:

(Check one answer for each question.)

NOT AT ALL

MODERATELY

SEVERE

Turning over in bed

Bending over, looking up

Standing up quickly

Rapid head movements

Walking in the dark

Uneven surfaces (e.g. grass or sand)

Elevators, escalators, stairs

Airplane, boat or car travel, scuba diving

To what extent is your dizziness or imbalance affected or brought on by :

(Check one answer for each question.)

	<u>NOT AT</u>	<u>MODERATELY</u>	<u>SEVERE</u>
	<u>ALL</u>		
Cough, sneeze, strain, laugh	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loud noises	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving objects, lights and windshield wipers, TV or movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moving your eyes with head still	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Are you dizzy with eyes closed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Touching your ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shopping malls, narrow or wide open spaces, supermarket	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tunnels, bridges, heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thinking about or anticipating going to specific places or being in specific situations that have produced dizziness in the past	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise (e.g., use of arms, jogging)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other activity (what?)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eating, missing meals, special foods, salt, sugar, monosodium gluconate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat, hot showers, or cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Time of day	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Depression, anxiety, nerves, or stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol or caffeine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual periods	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other questions concerning dizziness.

(If yes, GIVE DETAILS)

Can you bring on your dizziness voluntarily? YES
 NO

If you answered yes, please describe.

Do or did you have moderate-severe motion (car or boat) sickness?

Has anyone observed jerking of your eyes with dizzy spells?

3. HAVE YOU EVER EXPERIENCED THE FOLLOWING?

Migraine or other headaches

YES
 NO

If you answered yes, please answer the following:

Approximate age they began _____ Frequency of headaches _____
during the last 6 months _____ ; Pain intensity (1-10 with 10 the most severe) _____

Do your headaches usually
last 4 hours or more
start on one side of the head (which side?)
are throbbing or pulsatile in quality
are severe enough to interfere with your schedule
are aggravated by routine physical activity
are associated with nausea and/or vomiting
are aggravated by bright lights or loud noises
are brought on by cough, sneeze, or strain
are preceded by bright or flashing light or lines
require medications for pain - which medication and how often?
are usually relieved by dark rooms and/or sleep

4. **Have you ever had:** (If yes, **PLEASE GIVE DETAILS**).

	<u>YES</u>	<u>NO</u>
Infections of ears	<input type="checkbox"/>	<input type="checkbox"/>
Sinus disease	<input type="checkbox"/>	<input type="checkbox"/>
Inner ear disease (for example, labyrinthitis)	<input type="checkbox"/>	<input type="checkbox"/>
Difficulty with your hearing? Which ear?	<input type="checkbox"/>	<input type="checkbox"/>
Pain, fullness, popping or pressure in ear? Which ear?	<input type="checkbox"/>	<input type="checkbox"/>
Crossed eyes or lazy eye	<input type="checkbox"/>	<input type="checkbox"/>
Do you wear glasses? If so for reading, far viewing or both?	<input type="checkbox"/>	<input type="checkbox"/>
Ringing in ears (called tinnitus)	<input type="checkbox"/>	<input type="checkbox"/>
If you answered yes, please answer the following questions.	<input type="checkbox"/>	<input type="checkbox"/>

State the frequency and duration of the tinnitus.
 The tinnitus is primarily in the **LEFT**, **RIGHT** or **BOTH** ears.
 It is **STEADY**, **PULSATING**. It is **HIGH**, **LOW** pitched.

5. **REVIEW OF SYSTEMS** (If yes, **GIVE DETAILS**).

YES

- Loss _____
How much? _____
- Memory loss (amnesia),
change in handwriting _____
- Skin rash or birthmarks;
sores in mouth or genitals _____
- Muscle or joint
aches/swelling joints _____
- Fevers or swollen glands _____
- Problems with getting to sleep or staying asleep?
- Snoring?
- Do you nap during the day?

BEGINNING
WHEN?
or increase in weight.

REVIEW OF SYSTEMS (If yes, GIVE DETAILS).

YES

BEGINNING WHEN?

How many pillows do you use to sleep at night? _____

Burning in body or lump in throat

Abnormal menstrual periods

Shortness of breath

Milky discharge from breasts

Dry eyes or dry mouth

HAVE YOU EVER EXPERIENCED PROBLEMS WITH THE FOLLOWING?

YES

NO

Sense of smell

Sense of taste

Hair loss

Problems with hot or cold temperature

Black or blood stools

Trouble chewing or swallowing or speaking

Tremor or shakiness, stiffness, incoordination

Sweating, cold feelings

Chest pain

Palpitations (irregular or fast beating) of the heart

Pain in back of jaw (TMJ), grinding

Neck pain

6. **PAST MEDICAL HISTORY (GIVE DETAILS)** **YES** **NO**
HAVE YOU EXPERIENCED INJURIES?

HAVE YOU HAD SURGERY? **YES** **NO**
If yes please **DESCRIBE THE SURGERY** and **WHEN IT OCCURRED.**)

HAS YOUR PAST OR PRESENT HEALTH BEEN AFFECTED BY: **YES** **NO**
(If yes, **GIVE DETAILS**)

Neck pain

Heart problems

Diabetes

Low sugar (hypoglycemia)

Thyroid disorders

Treatment by a psychiatrist or counselor

Depression, anxiety, severe stress, phobias,
Psychiatric hospital admissions

High cholesterol

High or low blood pressure

	<u>YES</u>	<u>NO</u>
Loss of consciousness (faints)	<input type="checkbox"/>	<input type="checkbox"/>
Blood diseases, anemia	<input type="checkbox"/>	<input type="checkbox"/>
Skin diseases	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>
Gastrointestinal – (Stomach, colon, etc. – Ulcer disease)	<input type="checkbox"/>	<input type="checkbox"/>

List all major illnesses, injuries and surgeries not described above

Have you been exposed to any of the following?

(If yes, please describe the exposure and when it occurred)

	<u>YES</u>	<u>NO</u>
Poisons, gases, chemicals	<input type="checkbox"/>	<input type="checkbox"/>
Tropical diseases	<input type="checkbox"/>	<input type="checkbox"/>
Tick bites	<input type="checkbox"/>	<input type="checkbox"/>
Intravenous antibiotics	<input type="checkbox"/>	<input type="checkbox"/>
Military service overseas?	<input type="checkbox"/>	<input type="checkbox"/>
Travel to Central or South America, Asia, Africa	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusions within 10 years	<input type="checkbox"/>	<input type="checkbox"/>
Loud noise (guns, machinery, loud music)	<input type="checkbox"/>	<input type="checkbox"/>

Have you been exposed to any of the following?

(If yes, please describe the exposure and when it occurred)

YES

NO

Drug therapy for cancer (if yes, what type)

Medications for depression or anxiety, or psychiatric disease
(if yes, what type and when)

Lithium, Valium, Dilantin, Tegretol, sleeping pills, Xanax,
Ativan, Phenothiazine or any other tranquilizers or antidepressants
(If yes, what type and when)

HAVE YOU HAD ANY OF THE FOLLOWING INFECTIONS?: (If yes, GIVE DETAILS)

YES

NO

Syphilis or sexually-transmitted

Mononucleosis (Epstein Barr)

Lyme disease

Meningitis

Other infections

7. SOCIAL HISTORY

How much alcohol do you drink during an average week?

YES

NO

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)

Do you have any pets?

SOCIAL HISTORY CONT.

YES

NO

Do you have children? What are their ages? Their health?

Do you have brothers or sisters? Their ages? Their health?

8. FAMILY HISTORY

(If yes, please indicate which family member).

YES

NO

The same condition that you have

Migraine headaches

Multiple sclerosis

Hearing loss

Vertigo or dizziness

Balance problems

Tremor

Convulsions or seizures

Diabetes

Cancer

Brain tumors

Stroke

Heart disease

High blood pressure

Psychiatric disorders, depression or panic attacks

Other neurologic diseases

Any other conditions that run in the family

If your parents, brothers and sisters, or any children have died, at what age, and from what cause?

9. ALLERGIES TO MEDICATIONS:

Medication

Reaction

10. CURRENT MEDICATIONS:

What are your current medications, include hormones, birth control pills, vitamins, special diet, etc. (NAME AND AMOUNT/DAY)?

- | | |
|----|----|
| 1. | 5. |
| 2. | 6. |
| 3. | 7. |
| 4. | 8. |

What medications have you taken for your problem: steroids, chemotherapy, etc. by mouth or vein? (What DOSAGE, FOR HOW LONG, and EFFECTIVENESS?)

- 1.
- 2.
- 3.

11. HAVE YOU HAD A :

	<u>YES</u>	<u>RESULT</u>	<u>WHEN</u>
Hearing test	<input type="checkbox"/>	_____	_____
Evaluation by a neurologist	<input type="checkbox"/>	_____	_____
Evaluation by an ear doctor	<input type="checkbox"/>	_____	_____
Evaluation by an eye doctor	<input type="checkbox"/>	_____	_____
Evaluation by a psychologist/psychiatrist	<input type="checkbox"/>	_____	_____
Caloric test (water or air in ear)	<input type="checkbox"/>	_____	_____
MRI (was dye also given by injection?)	<input type="checkbox"/>	_____	_____
CT scan of the head or neck	<input type="checkbox"/>	_____	_____
Arteriogram or blood flow studies	<input type="checkbox"/>	_____	_____
Carotid artery blood flow studies	<input type="checkbox"/>	_____	_____
BAER (auditory evoked potentials)	<input type="checkbox"/>	_____	_____
SSEP (somatosensory evoked potentials)	<input type="checkbox"/>	_____	_____
VER (visual evoked potentials)	<input type="checkbox"/>	_____	_____
Sinus x-rays	<input type="checkbox"/>	_____	_____
Neck x-rays	<input type="checkbox"/>	_____	_____
Myelogram or MRI of neck	<input type="checkbox"/>	_____	_____
Spinal fluid examination	<input type="checkbox"/>	_____	_____
EEG (Brain Wave)	<input type="checkbox"/>	_____	_____
Electrochleography (ECOG)	<input type="checkbox"/>	_____	_____

12. HAVE YOU RECENTLY HAD:

	<u>YES</u>	<u>RESULT</u>	<u>WHEN</u>
Blood work	<input type="checkbox"/>	_____	_____
Urinalysis	<input type="checkbox"/>	_____	_____
Chest x-ray	<input type="checkbox"/>	_____	_____
Mammogram	<input type="checkbox"/>	_____	_____
GYN (pelvic) exam	<input type="checkbox"/>	_____	_____
Echo cardiogram	<input type="checkbox"/>	_____	_____
Holter monitor (24 hours)	<input type="checkbox"/>	_____	_____
Electrocardiogram	<input type="checkbox"/>	_____	_____
Lyme test	<input type="checkbox"/>	_____	_____
Glucose tolerance test (sugar)	<input type="checkbox"/>	_____	_____
B12 test	<input type="checkbox"/>	_____	_____
Thyroid test	<input type="checkbox"/>	_____	_____
AIDS test	<input type="checkbox"/>	_____	_____

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

IT IS VERY IMPORTANT TO COMPLETE THE ENTIRE PATIENT PROFILE (NEXT PAGE). THIS ALLOWS US TO REGISTER YOU INTO OUR SYSTEM. INCOMPLETE INFORMATION WILL DELAY THE APPOINTMENT PROCESS.

Patient Profile Multiple Sclerosis Program

Patient Information

Social Security # _____
Referring Physician: _____
Neurologist: _____

Tel Number: _____
Fax Number: _____
Tel Number: _____
Fax Number: _____

Patient Employment

Full Time Part Time Other _____

Employer: _____
Address: _____
Work Phone: _____

Guarantor

Guarantor's Information

Same as Patient

Employer: _____

Name: _____

Home Phone: _____

Address: _____

Work Phone: _____

Social Security #: _____

City, State: _____

Date of Birth: _____

Primary Insurance (All sections must be filled out)

Subscriber: _____

Relationship to Subscriber: _____

Insurance Carrier: _____

ID #: _____

Address: _____

Group #: _____

Phone: _____