KC Multiple Sclerosis Center
College Park Family Care Center - Neurology
10600 Mastin, Overland Park KS, 66212
Dr. Jeffrey Kaplan
Amy Dix,MPAS, PA-C, MSCS
Jennifer Ranvescroft, PA-C, MSCS

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
- Neuroopthamology/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
☐	**BetaSeron**		
☐	**Have you tested for antibodies against Interferon**		
☐	**Avonex**		
☐	**Have you tested for antibodies against Interferon**		
☐	**Extavia**		
☐	**Have you tested for antibodies against Interferon**		
☐	**Rebif**		
☐	**Have you tested for antibodies against Interferon**		
☐	**Copaxone**		
☐	**IV Steroids**		
☐	**Oral Steroids**		
☐	**Cytoxan**		
☐	**Methotrexate**		
☐	**IVIG**		
☐	**Azathioprine (Imuran)**		

☐ **Mycophenolate/Myfortic Acid(Cellcept)** _____ _____

☐ **Natalizumab (Tysabri)**
Tested against antibodies? ☐
Tested for JC Virus IgG Antibody? ☐ _____ _____

☐ **Rituninab** (Rituxan) _____ _____

☐ **Fingolimod/FTY-720** (Gilenya) _____ _____

☐ **Plasma exchange/plasma pheresis** _____ _____

☐ **Mitoxantrone** (Novantrone) _____ _____

☐ **IV Methotrexate** _____ _____

☐ **4-aminopyridine** (4-AP) (compound or Ampyra) _____ _____

☐ **Experimental agents** _____ _____

☐ **Stem Cell Treatment? Where?** _____ _____

☐ **CCSVI Treatment?(chronic cerebrospinal venous insufficiency) Where and When?** _____ _____

☐ **Other MS Medicine** _____ _____

☐ _____ _____

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

YES		WHEN?	IS IT ONGOING
☐	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?

YES		WHEN?	IS IT ONGOING
☐	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.)

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

Other questions concerning dizziness. (If yes, **GIVE DETAILS)**

	YES	NO
Can you bring on your dizziness voluntarily?	☐	☐
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?	**YES**	**NO**
Migraine or other headaches	☐	☐

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**).

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

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		BEGINNING WHEN?
☐	Loss	or increase ☐ in weight.
	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?	

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)** **HAVE YOU EXPERIENCED INJURIES?**	**YES** ☐	**NO** ☐

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

HAS YOUR PAST OR PRESENT HEALTH BEEN AFFECTED BY:

(If yes, **GIVE DETAILS)**	**YES**	**NO**
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	☐	☐

	YES	NO
Loss of consciousness (faints)	☐	☐
Blood diseases, anemia	☐	☐
Skin diseases	☐	☐
Arthritis	☐	☐
Lung disease	☐	☐
Kidney disease	☐	☐
Gastrointestinal – (Stomach, colon, etc. – Ulcer disease)	☐	☐

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)	YES	NO
Poisons, gases, chemicals	☐	☐
Tropical diseases	☐	☐
Tick bites	☐	☐
Intravenous antibiotics	☐	☐
Military service overseas?	☐	☐
Travel to Central or South America, Asia, Africa	☐	☐
AIDS	☐	☐
Blood transfusions within 10 years	☐	☐
Loud noise (guns, machinery, loud music)	☐	☐

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 :

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

12. HAVE YOU RECENTLY HAD:

	YES	RESULT	WHEN
Blood work	☐		
Urinalysis	☐		
Chest x-ray	☐		
Mammogram	☐		
GYN (pelvic) exam	☐		
Echo cardiogram	☐		
Holter monitor (24 hours)	☐		
Electrocardiogram	☐		
Lyme test	☐		
Glucose tolerance test (sugar)	☐		
B12 test	☐		
Thyroid test	☐		
AIDS test	☐		

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: _____ Tel Number: Fax Number: _____

Neurologist: _____ Tel Number: Fax Number: _____

Patient Employment

☐ Full Time ☐ Part Time ☐ Other _____

Employer: _____

Address: _____

Work Phone: _____

Guarantor

☐ **Same as Patient**

Name: _____

Address: _____

_____

City, State: _____

Guarantor's Information

Employer: _____

Home Phone: _____

Work Phone: _____

Social Security #: _____

Date of Birth: _____

Primary Insurance (All sections must be filled out)

Subscriber: _____ Relationship to Subsciber: _____

Insurance Carrier: _____ ID #: _____

Address: _____ Group #: _____

_____

Phone: _____