Steward MS Institute at Foxboro/Norwood Hospital

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Please bring this intake form with you to your appointment.

Demographic Information

Patient's Name:		Date:
Address:		
City:	State:	Zip:
Phone:	Marital Status:	
Spouse/ Care Partner Name		
Address:		
Phone: (H)	Phone: (W)	
Occupation:		

Referring Physician

Name:	Phone:	
Address:		
City:	State:	Zip:

Primary Physician

Name:	Phone:	
Address:		
City:	State:	Zip:

Reason for visit:

General Health Information

Age:	Weight:	Height:
Right Handed	Left Handed:	
Medication allergies:		

Have you been diagnosed with MS?		
Date of diagnosis:		
When did you experience your first symptoms?		
What were your symptoms?		
Have you ever had optic neuritis?	Yes	No
Have you ever had transverse myelitis?	Yes	No

Current Medication List

Please list all medications that you are currently taking including prescription and over the counter medications:

Medication	Dosage	Reason for taking	Dates Taken

Previous Medication List

Please list all medications that you have previously taken including prescription and over the counter medications

Medication	Dosage	Reason for taking	Dates Taken

Medical History

Which of these symptoms are you currently experiencing?		
Fatigue	Yes	No
Weakness- Upper extremities	Yes	No
Weakness- Lower extremities	Yes	No
Ambulation Problems (difficulty walking)	Yes	No
Memory Problems	Yes	No
Thought Process/ sequencing difficulties	Yes	No
Headaches	Yes	No
Loss of Vision	Yes	No
Abnormal sensation or numbness	Yes	No
Tingling/ pins and needles sensation	Yes	No
Tremors	Yes	No
Pain and Burning Sensation	Yes	No
Doubled or Blurred Vision	Yes	No
Hearing loss	Yes	No
Ringing in Ears	Yes	No
Vertigo or dizziness	Yes	No
Weight Loss	Yes	No
Weight Gain	Yes	No
Constipation	Yes	No
Loss of bowel control	Yes	No
Bladder Leakage	Yes	No
Bladder Urgency	Yes	No
Depression	Yes	No
Insomnia	Yes	No
Apathy or loss of interest	Yes	No
Suicidal thoughts	Yes	No
Agitation or anxiety	Yes	No
Visual hallucinations	Yes	No

Which of the medical conditions do you presently have or have had in the past?			
Diabetes	Yes	No	
Thyroid Disease	Yes	No	
Tuberculosis	Yes	No	
Asthma	Yes	No	
Anemia	Yes	No	
Cancer	Yes	No	
Stomach Ulcers	Yes	No	
Hepatitis	Yes	No	
Liver Problems	Yes	No	
High Blood Pressure	Yes	No	
Heart Rhythm Problems	Yes	No	
Heart Attack	Yes	No	
Stroke	Yes	No	
Epilepsy/Seizures	Yes	No	
Meningitis	Yes	No	
Kidney Disease	Yes	No	
Arthritis	Yes	No	
Skin Disease or Problems	Yes	No	
Gynecological Problems	Yes	No	N/A
Prostate Problems	Yes	No	N/A

Family History

Is there a family history of any chronic disease or illness?		
Stroke	Yes	No
Epilepsy	Yes	No
Cancer	Yes	No
Multiple Sclerosis	Yes	No
Heart Disease	Yes	No
Other Conditions	Yes	No
If so, relationship:	Illness/Disease	

Prior Surgical History:

Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Procedure:	Date:
Other Hospitalizations:	

Have you had any of the following:		
MRI of the brain?	Yes	No
When:		
MRI of the Spinal Cord?	Yes	No
When:		
Visual Evoked Response?	Yes	No
When:		
Brainstem Auditory Evoked Response?	Yes	No
When:		
Arm/Leg Evoked Responses?	Yes	No
When:		
Spinal Tap:	Yes	No
When:		
EMG/EEG?	Yes	No
When:		

Social History:

Are your parents still living?					
Mother	Yes	No	Father	Yes	No
Do you have?					
Brothers	Yes	No	Sisters	Yes	No
Children	Yes	No			
If any of the above are deceased please explain the age and cause of death:					
Have you ever been exposed to toxic substances?				Yes	No
Do you smoke?				Yes	No
Do you drink alcohol?				Yes	No
How much do you drink (units/week)?					
Where were you born and raised until 18 years of age?					
Who lives at home with you?					
Do you use:					
Cane:	Yes	No	Wheelchair:	Yes	No
Walker:	Yes	No	Drive a car:	Yes	No
Are you currently working:			Yes	No	
If so, what type of work do you do?					
What is your highest level of education?			Grammar School Grade:		
High School Grade?			College Graduate?	Yes	No

Are you disabled?	Yes	No	If yes, how long?

Review of Medical Conditions

Please check any of the following if it currently pertains to you:

General		Cardiac	
	Increased Fatigue		Angina
	Weight Loss		Irregular Heartbeat
	Fever		Heart Murmur
			Heart Failure
Skin			Rheumatic Fever
	Skin Cancer		
	Rash	Renal Urinary	
	Injection Site Reactions		Blood in Urine
Head/Neck			Kidney Stones
	Nose Bleeds		Urinary Tract Infection (UTI)
	Neck Injury		
	Hearing Loss	Gastrointestinal	
	Ears Ringing		Reflux
	Loss of Smell		Hiatal Hernia
	Hoarseness		Blood in Stool
	Glaucoma		Diverticulitis
	Macular Degeneration		Change in Bowel Habits
	Cataracts		
		Gynecological	
Respiratory			Irregular Menstrual Cycles
	Persistent Cough		Abnormal Vaginal Bleeding
	Shortness of Breath		Contraceptive Use
	Pneumonia		Pregnancies
	Bronchitis		

Other Comments: