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)*

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 #**	

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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

What is your current height? _____ What is your current weight? _____

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

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

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

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 _____

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.

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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?_____

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: