NEW PATIENT FORM
UPMC Neurology Department
Drs. Heyman, Zaydan, Xia, and Mr. Ryan Orie

Dear Patient: Please **complete** this form, and **bring it with you** to your appointment. It will help us care for you better. Thank you!

Name: _____ Date of birth: _____

Please circle one: Mr. Mrs. Ms. Miss Dr. Marital Status: _____

Address: _____ Home Phone: (_____)_____

_____ Cell Phone: (_____)_____

_____ Work Phone: (_____)_____

Your medical insurance company: _____

Your pharmaceutical insurance company: _____

Emergency Contact:

Name: _____ Relationship: _____

Address: _____ Phone Number: (_____)_____

_____

_____

Referring Physician:

Name: _____ Phone Number: (_____)_____

Address: _____ Fax Number: (_____)_____

_____

_____

Other Physicians or providers who should receive copies of correspondence:

Name: _____ Phone Number: (_____)_____

Address: _____ Fax Number: (_____)_____

_____

_____

Pharmacy (local):

Name: _____ Phone Number: (_____)_____

Address: _____ Fax Number: (_____)_____

_____

_____

Pharmacy (mail order):

Name: _____ Phone Number: (_____)_____

Address: _____ Fax Number: (_____)_____

_____

_____

Pharmacy (specialty):

Name: _____ Phone Number: (_____)_____

Address: _____ Fax Number: (_____)_____

_____

_____

Why did you schedule this appointment?

_____

_____

_____

_____

_____

_____

What health care evaluations and tests have already been done for your diagnosis?

Evaluation or Test (Circle Yes or No)		Approx Date	Where done?	Normal (N) or Abnormal (AN)	If abnormal, list details
MRI – Brain (most recent)	Yes/No				
MRI – Brain (2nd most recent)	Yes/No				
MRI – Brain (other date)	Yes/No				
MRI – Cervical Spine	Yes/No				
MRI – Thoracic Spine	Yes/No				
CT SCAN	Yes/No				
Lumbar Puncture (Spinal Tap)	Yes/No				
Visual Evoked Potentials	Yes/No				
Median (Arm) Sensory Evoked Potential	Yes/No				
Tibial (Leg) Sensory Evoked Potential	Yes/No				
Sed Rate	Yes/No				
Lyme Test	Yes/No				
Vitamin B12 Level	Yes/No				
TSH	Yes/No				
ANA	Yes/No				
NMO Titer	Yes/No				
CRP	Yes/No				
ACE	Yes/No				
CPK	Yes/No				
RF	Yes/No				

Have you ever taken any of the following medications? (<u>If you have a typed list of your current medications, please attach it to this packet.)</u>

Medication (Circle Yes or No)		Start Date	Stop Date	Reason discontinued
Betaseron/Extavia	Yes/No			
Avonex	Yes/No			
Copaxone/Glatopa	Yes/No			
Rebif	Yes/No			
Mitoxantrone (Novantrone)	Yes/No			
Tysabri	Yes/No			
Gilenya	Yes/No			
Aubagio	Yes/No			
Rituxan	Yes/No			
Cytoxan	Yes/No			
Methotrexate	Yes/No			
Imuran (Azathioprine)	Yes/No			
Cellcept (Mycophenolate)	Yes/No			
IVIGG	Yes/No			
Plegridy	Yes/No			
Zinbryta	Yes/No			
Tecfidera	Yes/No			
Lemtrada	Yes/No			

Have you ever received steroids for your neurological problems?

Steroid Name	Dose	Oral or IV	Dates Received

Please list all operations, surgeries, deliveries, and other hospitalizations:

Date (Year)	Reason for Hospitalization	Hospital & City

Social History:

1.) Are you right or left handed? _____

2.) What was the highest grade you completed? _____

3.) Do you currently use tobacco? ☐ yes ☐ no ☐ no, former user, I quit on _____

If yes, how many per day: _____cigarettes _____cigars _____chewing tobacco

4.) Number of alcoholic beverages per week: _____

5.) Do you have a living will? _____ Durable Power of Attorney? _____

*** If you answered yes to either of the above, please bring a copy to your appointment.**

Have you ever been diagnosed or treated for any of the following conditions?

Medical Condition (Circle Yes or No)		Year of onset	Medical Condition (Circle Yes or No)		Year of onset
High blood pressure/ hypertension	Yes/No		Seizures	Yes/No	
High cholesterol/fats	Yes/No		Lupus or rheumatoid arthritis	Yes/No	
Heart problems (attacks, failure, angina, atrial fibrillation, etc.)	Yes/No		Blood clots, thrombosis, embolism	Yes/No	
Stroke, ministroke, TIAs	Yes/No		Migraine or headache	Yes/No	
Cancer or tumors	Yes/No		Head injury or concussion	Yes/No	
Nervous breakdown, anxiety, depression, “nerves”	Yes/No		Neck or back injury, whiplash	Yes/No	
Kidney problems	Yes/No		Glaucoma, cataracts, macular degeneration	Yes/No	
Liver problems	Yes/No		Ulcers, gastritis, reflux, colitis	Yes/No	
Lung or breathing problems, asthma, emphysema, bronchitis	Yes/No		Diabetes, high blood sugar	Yes/No	
Thyroid problems	Yes/No				

Please list any additional medical conditions/problems:

Medical Condition (Circle Yes or No)	Year of onset	Medical Condition (Circle Yes or No)	Year of onset

Family History:

Relationship	Age	Living/Deceased	Health Status/ Notable Illnesses
Mother			
Father			
Sibling			
Sibling			
Sibling			
Sibling			
Children			
Children			
Children			
Children			
Children			

Does anyone in the family have MS? ☐ yes ☐ no

If yes, please indicate their relationship to you: _____

Does anyone in the family have any other **autoimmune** disorders? ☐ yes ☐ no

If yes, please indicate the disorder and their relationship to you:

Disorder	Relationship	Disorder	Relationship

Does anyone in the family have any other **neurological** disorders? ☐ yes ☐ no

If yes, please indicate the disorder and their relationship to you:

Disorder	Relationship	Disorder	Relationship

Current Medications, Injections, & Supplements Taken:

Please include any vitamins, supplements, pain relief, cold medication, shots, topical creams/patches, sprays, suppositories, injections, etc. **(If you have a typed list of your current medications containing all this information, please skip this section and attach the list.)**

Medication	Pill Size/Strength	How Many/How Often

Allergies/Sensitivity:

Medication/Substance	Reaction	Medication/Substance	Reaction

Neurologic Status

What is your diagnosis? _____

How do you feel you are doing? ☐ improved ☐ stable ☐ somewhat worse ☐ a lot worse

Please list your **most important** questions/issues for today's appointment (maximum of 3):

1) _____

2) _____

3) _____

A) How often do you exercise? ☐ never ☐ 1/week or less ☐ 2-3/week ☐ more than 3/week

B) Do you take a vitamin D supplement? ☐ yes ☐ no

C) Do you smoke tobacco? ☐ yes ☐ no

D) How is the stress level in your home? ☐ low ☐ moderate ☐ high ☐ very high

E) Are you working?

☐ yes, full time ☐ yes, part time ☐ no, not on a disability ☐ partial disability ☐ total disability

1. Do you have excessive fatigue? ☐ no ☐ mild ☐ moderate ☐ severe
2. Do you awaken refreshed from sleep? ☐ yes ☐ no
3. Do you have decreased muscle power in your right arm? ☐ no ☐ mild ☐ moderate ☐ severe
4. Do you have decreased muscle power in your right leg? ☐ no ☐ mild ☐ moderate ☐ severe
5. Do you have decreased muscle power in your left arm? ☐ no ☐ mild ☐ moderate ☐ severe
6. Do you have decreased muscle power in your left leg? ☐ no ☐ mild ☐ moderate ☐ severe
7. Do you have decreased muscle power in your trunk? ☐ no ☐ mild ☐ moderate ☐ severe
8. Do you have any muscle stiffness, spasms, or contractions?

   ☐ no ☐ yes, right body ☐ yes, left body ☐ yes, both sides
9. Have you fallen in the last 12 months?

   ☐ no ☐ once ☐ less than 1 fall/month ☐ more than 1 fall/month ☐ more than 1 fall/week
10. Do you use an assistive device for mobility? ☐ yes ☐ no

    If yes, please indicate all of those that apply:

    ☐ cane ☐ standard walker ☐ rolling walker ☐ wheelchair ☐ scooter ☐ power wheelchair
11. Are you having blurred vision? ☐ no ☐ right eye ☐ left eye ☐ both eyes

12. Do you have an enlarged blind spot or missing parts of your vision?

☐ no ☐ right eye ☐ left eye ☐ both eyes

13. Do you have loss of color vision or decreased brightness? ☐ no ☐ right eye ☐ left eye ☐ both eyes

14. Do you have eye pain? ☐ no ☐ right eye ☐ left eye ☐ both eyes

15. Do you have double, jumpy, or jerky vision? ☐ yes ☐ no

16. Do you have difficulty controlling your bladder? ☐ no problems ☐ urgency/rushing

☐ hesitancy/slowness to start or need to empty again soon after going

17. On a typical night, how often do need to empty your bladder?

☐ 0-1 time ☐1-2 times ☐ 2-3 times ☐ more than 3 times

18. Do you ever use a catheter to empty your bladder?

☐ no ☐ external male catheter ☐ self-intermittent catheter (_____ times a day)

☐ foley (urethral) catheter ☐ suprapubic catheter

19. How often do you lose control of your urine?

☐ never ☐ rarely ☐ sometimes ☐ almost every day ☐ at least once daily

20. Do you require pads, diapers, or other incontinence products?

☐ never ☐ some days ☐ daily

21. How many bladder infections have you had in the last year? ☐ none ☐ 1 ☐ 2 ☐ 3 or more

22. Do you have bowel trouble?

☐ no problems ☐ diarrhea ☐ constipation ☐ staining/seepage ☐ incontinence

23. How frequently do you usually have a bowel movement? (Choose one.)

☐ once daily ☐ more than once daily ☐ 3-5 times per week ☐ less than once weekly

24. Do you currently have numbness or tingling? ☐ no ☐ yes, right arm ☐ yes, right leg

☐ yes, left arm ☐ yes, left leg ☐ yes, face/ head ☐ yes, whole body

25. Do you currently have any tremor or shaking? ☐ no ☐ yes, right arm ☐ yes, right leg

☐ yes, left arm ☐ yes, left leg ☐ yes, whole body

26. Do you currently have pain anywhere? ☐ no ☐ yes, right arm ☐ yes, right leg

☐ yes, left arm ☐ yes, left leg ☐ yes, back/spine ☐ yes, whole body

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

A. Little interest or pleasure in doing things:

☐ not at all ☐ several days ☐ more than ½ the days ☐ nearly every day

B. Feeling down, depressed or hopeless:

☐ not at all ☐ several days ☐ more than ½ the days ☐ nearly every day

Patient Determined Disease Steps

Please read the choices listed below and choose the one that best describes your own situation. **This scale focuses mainly on how well you walk.** You might not find a description that reflects your condition exactly, but please mark the **ONE** category that describes your situation the closest.

☐ 0 I may have some mild symptoms, mostly sensory due to MS/neurologic condition but they do not limit my activity. If I do have an attack, I return to normal when the attack has passed.

☐ 1 I have some noticeable symptoms from my MS/neurologic condition but they are minor and have only a small effect on my lifestyle.

☐ 2 I don't have any limitations in my walking ability. However, I do have significant problems due to MS/neurologic condition that limit daily activities in other ways.

☐ 3 My MS/neurologic condition does interfere with my activities, especially my walking. I can work a full day, but athletic or physically demanding activities are more difficult than they used to be. I usually don't need a cane or other assistance to walk, but I might need some assistance during an attack.

☐ 4 I use a cane or a single crutch or some other form of support (such as touching a wall or leaning on someone's arm) for walking all the time or part of the time, especially when walking outside. I think I can walk 25 feet in 20 seconds without a cane or crutch. I always need some assistance (cane or crutch) if I want to walk as far as 3 blocks.

☐ 5 To be able to walk 25 feet, I have to have a cane, crutch or someone to hold onto. I can get around the house or other buildings by holding onto furniture or touching the walls for support. I may use a scooter or wheelchair if I want to go greater distances.

☐ 6 To be able to walk as far as 25 feet I must have 2 canes or crutches or a walker. I may use a scooter or wheelchair for longer distances.

☐ 7 My main form of mobility is a wheelchair. I may be able to stand and/or take one or two steps, but I can't walk 25 feet, even with crutches or a walker.

☐ 8 Unable to sit in a wheelchair for more than one hour.

MSRS-R Assessment of Your Current Functioning

Please circle the number under the description that best matches your symptoms for each activity in the far left column. You might not find a description that reflects your condition exactly, but please circle the **ONE** category that describes your situation the closest.

ACTIVITY	No Symptoms	Some symptoms, no disability	Mild disability	Moderate disability	Severe disability
	"I have no symptoms or disability in this specific area"	"I am aware of symptoms but no limits on my activities"	"I have mild limits on my activities, but I do not need help from others or to use other aides"	"I have moderate limits on my activities and I sometimes need help from others or use other aides"	"I have severe limits on my activities and I usually need help from others or use other aides"
Walking	**0**	**1**	**2**	**3**	**4**
Using your arms and hands	**0**	**1**	**2**	**3**	**4**
Vision	**0**	**1**	**2**	**3**	**4**
Speech	**0**	**1**	**2**	**3**	**4**
Swallowing	**0**	**1**	**2**	**3**	**4**
Thinking, memory or cognition	**0**	**1**	**2**	**3**	**4**
Numbness, tingling, burning sensation or pain	**0**	**1**	**2**	**3**	**4**
Controlling your bladder and/or bowel	**0**	**1**	**2**	**3**	**4**

Review of Systems

1. Over the last 6 months is your weight ☐ stable ☐ gained > 5 pounds ☐ lost > 5 pounds
2. Have you had any blackouts or fainting? ☐ yes ☐ no
3. Have you had any seizures? ☐ yes ☐ no
4. Have you noticed any blood in your urine? ☐ yes ☐ no
5. Have you noticed any blood in your stool/bowel movements? ☐ yes ☐ no
6. Do you have any open wounds or sores on your skin? ☐ yes ☐ no
7. Have you had any increase of your blood sugar? ☐ I don't know ☐ yes ☐ no
8. Do you have dry eyes? ☐ yes ☐ no
9. Have you been having chest pains? ☐ yes ☐ no
10. Have you been having irregular heart rate or rhythm? ☐ yes ☐ no
11. Have you had any dental or dry mouth problems? ☐ yes ☐ no
12. Do you have any red swollen joints? ☐ yes ☐ no
13. Have you had any hallucinations? ☐ yes ☐ no
14. Do you have breathing problems? ☐ no ☐ only with activity ☐ even while at rest