**Oklahoma Medical Research Foundation**
**Multiple Sclerosis Center of Excellence**
820 Northeast 15th Street
Oklahoma City, OK 73104
405-271-6242
Fax: 405-271-2887
omrf.org/MSCenter

# Health History

Today's Date: _____
Patient's Name: _____
Birthdate: _____
Address: _____
Phone No: _____
Are you Right or Left Handed? (circle one)
Referring Physician: _____
Family Physician: _____
Pharmacy: _____

**Chief Complaint**

_____
_____
_____
_____

Have you seen other physicians for your current complaint?
If yes, please list the physicians and dates you saw them in.

_____
_____
_____
_____

Have you had treatment for you current complaints? Yes or No
If yes, please state approximately when and by whom.

_____
_____
_____
_____

**CT'S, MRI'S,ULTRASOUND, X-RAYS, OR OTHER DIAGNOTIC TESTING**
Have you had CT'S, MRI'S, Ultrasounds or X-Rays made for your current complaints? Yes or No
If yes, by whom.

_____
_____
_____
_____

**PAST SURGICAL HISTORY**
List and indicate approximate year.

_____
_____
_____

**CURRENT MEDICATIONS OR ATTACH MEDICATION LIST**

_____
_____
_____
_____
_____
_____

**ALLERGIES**

_____
_____
_____
_____

**PAST HISTORY (PERSONAL)**

| | | | |
|---|---|---|---|
| Measles | Yes | No | |
| Mumps | Yes | No | |
| Chicken pox | Yes | No | |
| Whooping Cough | Yes | No | |
| Scarlet Fever | Yes | No | |
| Diphtheria | Yes | No | |
| Smallpox | Yes | No | |
| Pneumonia | Yes | No | |
| Rheumatic Fever | Yes | No | |
| Heart Disease | Yes | No | |
| Heart Surgery | Yes | No | |
| Pacemaker | Yes | No | |
| Heart Valve Replacement | Yes | No | |
| Anemia | Yes | No | |
| Epilepsy | Yes | No | |
| Migraine Headaches | Yes | No | |
| Tuberculosis | Yes | No | |
| Diabetes | Yes | No | |
| Cancer | Yes | No | Type |
| | | | |
| Polio | Yes | No | |
| Glaucoma | Yes | No | |
| Hernia | Yes | No | |
| Blood Transfusion | Yes | No | |
| Back Trouble | Yes | No | |
| High Blood Pressure | Yes | No | |
| Hemorrhoids | Yes | No | |
| Asthma | Yes | No | |
| Bladder Infections | Yes | No | |
| Colitis | Yes | No | |
| Bleeding Tendency | Yes | No | |
| Bronchitis | Yes | No | |
| Stroke | Yes | No | |
| Emphysema | Yes | No | |
| Ulcer | Yes | No | |
| Kidney Disease | Yes | No | |
| Thyroid Disease | Yes | No | |
| AIDS/HIV | Yes | No | |
| Angina Pectoris | Yes | No | |
| Gout | Yes | No | |
| Frequent Lung infections | Yes | No | |
| Lupus | Yes | No | |

**FAMILY HISTORY**

| | | | Relationship | | | | Relationship |
|---|---|---|---|---|---|---|---|
| Multiple Sclerosis | Yes | No | _____ | Stroke | Yes | No | _____ |
| Tuberculosis | Yes | No | _____ | Epilepsy | Yes | No | _____ |
| Diabetes | Yes | No | _____ | Allergies | Yes | No | _____ |
| Heart Disease | Yes | No | _____ | Anemia | Yes | No | _____ |
| High blood pressure | Yes | No | _____ | Bleeding Tendency | Yes | No | _____ |
| Asthma | Yes | No | _____ | Chronic Lung Disease | Yes | No | _____ |
| Drug/Alcohol Problems | Yes | No | _____ | Dementia/Alzheimer's | Yes | No | _____ |
| Migraine Headaches | Yes | No | _____ | Thyroid Disease | Yes | No | _____ |
| Cancer | Yes | No | _____ | Depression | Yes | No | _____ |
| High Cholesterol | Yes | No | _____ | Kidney Disease | Yes | No | _____ |
| Glaucoma | Yes | No | _____ | Gout | Yes | No | _____ |
| Parkinson's | Yes | No | _____ | Neck/Back Trouble | Yes | No | _____ |
| Tremor | Yes | No | _____ | Neuropathy | Yes | No | _____ |

**PERSONAL HABITS**

1. Check if you smoke regularly.
   Cigarettes _____ Number per day ____ Pipe ___ Cigar ____
   How long have you been smoking? _____
2. Check if you drink regularly.
   Hard liquor 1 - 3 oz day _____ Over 3 oz per day ____
   Beer 1 bottle per day ____ 2 bottles per day ____ 3 or more bottles per day ____
   Wine 1 glass per day ____ 2 glasses per day ____ 3 or more glasses per day ____
3. Do you drink coffee, tea or soft drinks?
   3 or more cups per day ____ Caffeinated ____ Decaffeinated ____
4. Do you have trouble sleeping? Never ____ Often ____ Sometimes _____
5. Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
   Frequently _____ Occasionally _____ Rarely ____
6. Do you use marijuana, cocaine or other drugs? Yes _____ No _____

**OCCUPATIONAL**

What is your occupation? _____
Are you presently employed? Yes No

**MARITAL/FAMILY**

What is your marital status?
Married ____ Single _____ Widowed ____ Divorced _____

| | | |
|---|---|---|
| Have there been any deaths in your family or among close friends in the past year or two? | Yes | No |
| Does anyone in your family have a serious illness or disability? | Yes | No |
| Does anyone in your family have a drug or alcohol problem? | Yes | No |

**SOCIAL HISTORY**

| | | |
|---|---|---|
| Have you recently lived or traveled outside the U.S.? | Yes | No |
| Are you a high school graduate or equivalent? | Yes | No |
| Did you attend or complete college? | Yes | No |
| Have you ever served in the military? | Yes | No |
| Have you ever been rejected for life or health or had to pay an extra premium? | Yes | No |
| Have you ever been treated for a drinking problem? | Yes | No |

**CURRENT PHYSICAL/OT/OR SLP** **PAST THERAPIES DATES**

_____ _____
_____ _____
_____ _____
_____ _____

Patient Name_____ DOB _____

# Review of Systems:

**1. General**

| | | |
|---|---|---|
| Do you feel depressed a lot of the time? | Yes | No |
| Has there been any unusual weight gain? | Yes | No |
| or loss recently? | Yes | No |
| If yes, Gained _____ Loss ____ Stable _____ | | |
| If gained or loss how much? _____ | | |

**1. Skin**

| | | |
|---|---|---|
| Have you noticed? | | |
| The appearance of new dark spots? | Yes | No |
| Any skin rashes or itching? | Yes | No |
| Any growths on your skin that bothers you? | Yes | No |
| Any sores or wounds that do not heal? | Yes | No |
| Any change in color or size of warts or moles? | Yes | No |

**2. Eyes**

| | | |
|---|---|---|
| Have you had any pain in your eyes? | Yes | No |
| Have you had glaucoma? | Yes | No |

**3. Ear, Nose, Throat**

| | | |
|---|---|---|
| Any trouble hearing? | Yes | No |
| Ringing or buzzing in your ears? | Yes | No |
| A lump in your throat? | Yes | No |
| A sore tongue or mouth? | Yes | No |
| Bleeding gums? | Yes | No |
| Difficultly speaking or swallowing | Yes | No |

**4. Respiratory**

| | | |
|---|---|---|
| Do you have: | | |
| A constant or bothersome cough? | Yes | No |
| Coughing of blood? | Yes | No |
| Difficulty breathing? | Yes | No |
| Have you noticed any wheezing or whistling in your chest? | Yes | No |

**5. Cardiovascular**

| | | |
|---|---|---|
| Do you have pain, tightness or pressure in front or back of your chest? | Yes | No |
| electrocardiogram was abnormal? | Yes | No |
| Do you have swelling of you feet or Ankles? | Yes | No |
| Does your heart ever beat fast or irregularly? | Yes | No |
| Do you have cramps in the calf muscles when you walk? | Yes | No |

**6. Gastrointestinal**

| | | |
|---|---|---|
| Have your recently noted any trouble Swallowing? | Yes | No |
| Do you have a lot of indigestion or Heartburn? | Yes | No |
| Have you ever vomited blood? | Yes | No |
| Are you bothered with constipation? | Yes | No |
| Do you have frequent nausea and/or vomiting? | Yes | No |
| Do you have frequent loose stools or diarrhea? | Yes | No |
| Have you ever passed blood from your rectum? | Yes | No |
| Have you ever had black or tarry stools? | Yes | No |
| Have you noticed any recent changes in your bowel movements? | Yes | No |

**8. Genitourinary**

| | | |
|---|---|---|
| Do you have: | | |
| Burning or pain when you urinate? | Yes | No |
| To urinate frequently? | Yes | No |
| Trouble urinating? | Yes | No |
| To get up at night to urinate? | Yes | No |
| Trouble with losing urine when you you cough or sneeze? | Yes | No |
| Have you ever passed blood in you urine? | Yes | No |
| Men, do you have prostate gland trouble? | Yes | No |

**9. Musculoskeletal**

| | | |
|---|---|---|
| Do you have a problem with back pain? | Yes | No |
| Does back pain interfere with your work or activities? | Yes | No |
| Frequent or severe nosebleeds? | Yes | No |
| Do you have joint pain, stiffness or swelling? | Yes | No |
| Falls or fear of falling? | Yes | No |

**10. Central Nervous System**

| | | |
|---|---|---|
| Do you have frequent or severe headaches? | Yes | No |
| Do you often have spells of dizziness, faintness or lightheadedness? | Yes | No |
| Have you ever see double vision? | Yes | No |
| Do you sometimes lose track of what is around you for a short time? | Yes | No |
| Do you sometimes lose the ability to speak for a few seconds? | Yes | No |
| Have you recently fainted, blacked out or lost consciousness? | Yes | No |
| Do you have trouble remembering recent events? | Yes | No |
| Have you ever had convulsions or fits? | Yes | No |
| Do you have numbness or tingling in your head, arms or legs? | Yes | No |

**11. Women Only**

A. **Premenopausal women:**

| | | |
|---|---|---|
| Did your menstrual period start after you were 15? | Yes | No |
| Are you menstrual periods irregular? | Yes | No |
| Do you use more than 10 pads or have to use a super size pad or tampon for you periods? | Yes | No |
| Do you pass clots with you periods? | Yes | No |
| Do you become bloated or gain weight just before you periods? | Yes | No |

B. **Postmenopausal women**:

At what age did you go through the menopause? _____

C. **All women:**

| | | |
|---|---|---|
| Have you had any abortions or miscarriages? | Yes | No |
| Have you had any lumps in your breasts? | Yes | No |
| Have you ever had a mammogram? | Yes | No |
| If so, when? _____ | | |

Patient Name_____ DOB _____