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

HEALTH HISTORY

Today's Date: _____

Patient's Name: _____ Patient's Date of Birth: _____

Preferred Pharmacy (name and phone number): _____

Is patient right or left handed: ____Right ____Left

Chief Complaint(s):

_____

_____

_____

Have you seen other physicians for your current complaint? If yes, please list the physicians and approximate office visit dates.

_____

_____

_____

Disease modifying therapies tried for MS. Please include drug name, start and stop dates.

_____

_____

_____

Date, facility and type (brain, C-spine, T-spine) of your last MRI(s).

_____

_____

Past Surgical History. Please list type of surgery and approximate year.

_____

_____

_____

Have you had a spinal tap or lumbar puncture? If so, when and where was it done?

_____

_____

Current medications. Please include the name of the medication, dose, start date and ordering physician. Continue on back if necessary.

_____

_____

_____

_____

_____

_____

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(Revised 8/2019 ts)

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Allergies:

_____

_____

_____

General:

Do you feel depressed a lot of the time?	Yes	No
Has there been any unusual weight gain or loss recently?	Yes	No

If yes, gained _____ loss _____
If weight loss or gain, indicate pounds. _____

Skin:

Have you noticed:

Any skin rashes or itching?	Yes	No
Any sores or wounds that do not heal?	Yes	No
Excessive dry skin	Yes	No

Eyes:

Have you had any pain in your eyes?	Yes	No
Have you had uveitis/iritis?	Yes	No
Blurry vision?	Yes	No
Double Vision?	Yes	No

Ears, Nose, Throat

Trouble hearing?	Yes	No
Ringing or buzzing in your ears?	Yes	No
A sore tongue or mouth?	Yes	No
Difficulty speaking or swallowing?	Yes	No

Respiratory

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

Cardiovascular

Do you have pain, tightness or pressure in front or back of your chest?	Yes	No
Have you had an abnormal electrocardiogram?	Yes	No

Cardiovascular (continued)

Do you have swelling of your feet or ankles?	Yes	No
Does your heart ever beat fast or irregularly?	Yes	No

Gastrointestinal

Have you 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 by constipation?	Yes	No
Do you have frequent nausea and/or vomiting?	Yes	No
Do you have frequent loose stools or diarrhea?	Yes	No
Do you have constipation?	Yes	No
Have you noticed any recent changes in your bowel movements?	Yes	No

Genitourinary

Urinate frequently?	Yes	No
Urge to urinate?	Yes	No
Incontinence of urine?	Yes	No
Trouble urinating?	Yes	No
Get up at night to urinate?	Yes	No
Trouble with losing urine when you cough or sneeze?	Yes	No
Men, do you have prostate gland trouble?	Yes	No

Musculoskeletal

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

Central Nervous System

Do you have frequent or severe headaches?	Yes	No
Do you often have spells of dizziness, faintness or lightheadedness?	Yes	No
Do you have double vision?	Yes	No

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Central Nervous System (continued)

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

Women Only

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 yes, when? _____

Postmenopausal Women Only:
At what age did you go through menopause? _____

Personal Habits

Smoking:

Do you smoke regularly? If so,
___ Cigarettes ___ number per day
___ Pipe
___ Cigars ___ number per day
How long have you smoked? _____

Drinking:

____ Hard liquor ____ 1-3 oz/day
____ 3+ oz/day
____ Beer ____ 1 bottle/day
____ 2 bottles/day
____ 3+ bottles/day
____ Wine ____ 1 glass/day
____ 2 glasses/day
____ 3+ glasses/day

Do you drink coffee, tea or soft drinks?
3 or more cups per day Yes No

Do you use marijuana, cocaine or other drugs?
___ Yes ___ No

Sleeping:

Do you have trouble sleeping?
___ Never ___Often ___Sometimes

Do you awaken very early in the morning without apparent cause and find it difficult to fall asleep again?
___ Never ___Often ___Sometimes

Occupational

Are you presently employed? ___Yes ___ No

What is your occupation?

_____

Level of Education:
_____ Elementary school
_____ High school
_____ Some college
_____ Completed college
_____ Professional school

Social History

Have you recently lived or traveled outside the USA? Yes No
Have there been any deaths in your family or among close friends in the past two years? Yes No
Does anyone in your family have a drug or alcohol problem? Yes No
Does anyone in your family have a serious illness or disability? Yes No
Have you ever served in the military? Yes No
Have you ever been rejected for life or health insurance or had to pay an extra premium? Yes No
Have you ever been treated for a drinking problem? Yes No

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Do you or a family member currently have or have had any of the following conditions:

	PATIENT		FAMILY MEMBER	
		COMMENT		***Relationship to Patient***
Multiple Sclerosis	___Yes	_____	___Yes	_____
Tuberculosis	___Yes	_____	___Yes	_____
Diabetes	___Yes	_____	___Yes	_____
High blood pressure	___Yes	_____	___Yes	_____
Cancer	___Yes	_____	___Yes	_____
High Cholesterol	___Yes	_____	___Yes	
Tremor	___Yes	_____	___Yes	_____
Sleep apnea	___Yes	_____	___Yes	_____
Fibromyalgia	___Yes	_____	___Yes	_____
Arthritis	___Yes	_____	___Yes	_____
Hepatitis	___Yes	_____	___Yes	_____
Inflammatory bowel disease	___Yes	_____	___Yes	_____
Epilepsy	___Yes	_____	___Yes	_____
Allergies	___Yes	_____	___Yes	_____
Anemia	___Yes	_____	___Yes	_____
Bleeding tendency	___Yes	_____	___Yes	_____
Chronic lung disease	___Yes	_____	___Yes	_____
Asthma	___Yes	_____	___Yes	_____
Thyroid disease	___Yes	_____	___Yes	_____
Kidney disease	___Yes	_____	___Yes	_____
Neck/back trouble	___Yes	_____	___Yes	_____
Neuropathy	___Yes	_____	___Yes	_____
Migraine headaches	___Yes	_____	___Yes	_____
Stroke	___Yes	_____	___Yes	_____
Parkinson's	___Yes	_____	___Yes	_____
Dementia/Alzheimer's	___Yes	_____	___Yes	_____
Anxiety disorder	___Yes	_____	___Yes	_____
Depression	___Yes	_____	___Yes	_____
Psychotic disorder	___Yes	_____	___Yes	_____
Schizophrenia	___Yes	_____	___Yes	_____
Bipolar disorder	___Yes	_____	___Yes	_____
ADHD	___Yes	_____	___Yes	_____
Cardiac arrhythmia	___Yes	_____	___Yes	_____
Heart Disease	___Yes	_____	___Yes	_____
Coronary artery disease	___Yes	_____	___Yes	_____
Congestive heart failure	___Yes	_____	___Yes	_____
Peripheral artery disease	___Yes	_____	___Yes	_____
Cataracts	___Yes	_____	___Yes	_____
Glaucoma	___Yes	_____	___Yes	_____
Macular edema	___Yes	_____	___Yes	_____
Drug/alcohol abuse	___Yes	_____	___Yes	_____

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