

Neurologist:

PERSONAL DATA

NAME: _____ Date of birth: _____
Day Month Year

First name: _____ Male Female

Birth name: _____ Current residence (county): _____

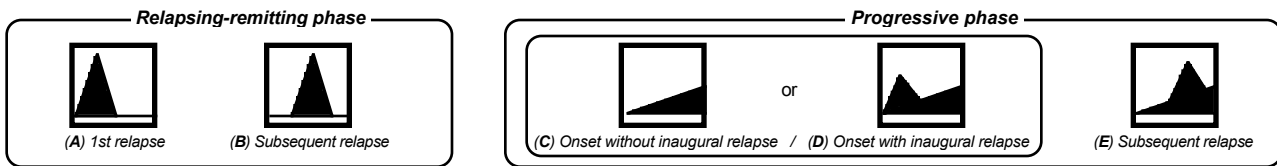
Domestic status

- Alone
- With spouse/partner
- With other relative
- Nursing or sheltered home

Employment status

- Full time work (incl. students)
- Part time work
- Unemployed (due to MS)
- Homemaker
- Other (child, retired, looking for work)

HISTORY OF NEUROLOGICAL EPISODES



		MS Onset				
Date of onset of episode	Month	____	____	____	____	____
	Year	____	____	____	____	____
Episode type	<i>(cf. classification above)</i>	____	____	____	____	____

Semiology of the episode

Unknown	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lower extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Upper extremity dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sensory symptoms (pain, paresthesia, Lhermitte)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bladder/ bowel dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sexual dysfunction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oculomotor impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial motor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Facial sensory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vertigo, hypoacusia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Speech / swallowing impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reduced visual acuity (optic neuritis)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental deterioration	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Paroxysmal symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Episode features

Hospitalization	<i>No / Yes</i>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>
Corticosteroid treatment	<i>No / Yes</i>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/>
	<i>If yes, i.v. / i.m. / per os</i>	<input type="radio"/> — <input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/> — <input type="radio"/>	<input type="radio"/> — <input type="radio"/> — <input type="radio"/>

