

Dr. Vincent Macaluso MS intake form

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Date of Office Visit _____

Name _____

Social Security Number ____ - ____ - _____

Birthdate _____

Street Address _____

City/Town _____

State _____

Zip code _____ - _____

Marital Status (Please Check One)

SINGLE___ MARRIED___ SEPARATED___ DIVORCED___ WIDOWED___

Home Phone: (____) _____ - _____

Work phone: (____) _____ - _____

Cell phone: (____) _____ - _____

email _____ @ _____

Occupation _____

Insurance plan #1

Plan Name _____

Policy/ID Number _____

Group Number _____

Policy Holder Name _____

Policy Holder Social Security # _____

Policy Holder Date of Birth _____

Insurance plan #2

Plan Name _____

Policy/ID Number _____

Group Number _____

Policy Holder Name _____

Policy Holder Social Security # _____

Policy Holder Date of Birth _____

Referring physician's name: _____

address: _____

phone number: (____) _____

fax number: (____) _____

Are you claustrophobic? - this is to tell us if you might require an open MRI if needed

Yes: _____ No: _____

Do you have any allergies? _____

Please list any surgeries and the dates that you had them

Please list any current medical problems that you have (MS, Migraines, High Blood Pressure, Diabetes, etc.) _____

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Which hand do you usually write with? RIGHT___ LEFT___
When did the symptoms of your MS start? _____
What were those symptoms? _____

When were you diagnosed with MS? _____
What were the symptoms that you had when you went for diagnosis _____

When was your last exacerbation? _____
Have you ever been treated with intravenous steroids? ___ Yes ___ No

Which of the following symptoms have you had in the past:

Visual changes:

Loss of vision in the right eye___.
Loss of vision in the left eye___.
Loss of vision in both eyes___.
blurred vision in the right eye___.
blurred vision in the left eye___.
No visual changes have been noticed___.

Weakness:

on the right:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

on the left:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

Tingling (pins and needles):

on the right:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

on the left:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

Lack of sensation:

on the right:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

on the left:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

Incoordination:

on the right:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

on the left:

arm___.
hand___.
leg___.
foot___.
trunk___.
none noticed___.

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Please check any of the following items that you have trouble with:

- walking__.
- double vision__.
- extreme fatigue__.
- cognitive changes__.
- memory__.
- remembering tasks__.
- concentration__.
- processing speed__.
- word production__.
- urinary urgency__.
- urinary frequency__.
- urinary hesitancy__.
- urinary incontinence__.
- fecal urgency__.
- fecal hesitancy__.
- fecal incontinence__.
- constipation__.
- sexual interest__.
- sexual arousal__.
- orgasm__.
- sexual satisfaction__.
- changes in mood__.

Previous medications:

Have you ever been tried on any of the following to slow down your multiple sclerosis:

- Avonex__.
- Betaseron__.
- Rebif__.
- Copaxone__.
- natalizumab (Tysabri)__.
- mycophenolate mofetil (CellCept)__.
- Cyclophosphamide (Cytoxan)__.
- Mitoxantrone (Novantrone)__.
- Other therapies (study medication, bee stings, low dose naltrexone, etc.) _____
- _____
- _____
- nothing__.

What therapy are you currently on?:

- Avonex__.
- Betaseron__.
- Rebif__.
- Copaxone__.
- natalizumab (Tysabri)__.
- mycophenolate mofetil (CellCept)__.
- Cyclophosphamide (Cytoxan)__.
- Mitoxantrone (Novantrone)__.
- Other therapies (study medication, bee stings, low dose naltrexone, etc.) _____
- _____
- _____
- nothing__.

FAMILY HISTORY

Please list any medical conditions that your relatives have/had
(if they have no medical conditions please indicate "Good Health")

	Alive	Deceased	medical problems
Mother	_____	_____	_____
Father	_____	_____	_____
Brothers	# that are _____	_____	_____
Sisters	# that are _____	_____	_____
Daughters	# that are _____	_____	_____
Sons	# that are _____	_____	_____

Do you have any relatives with chronic disease (like lupus, sarcoidosis, Chron's disease, Sjogren's disease, etc.) : _____

Do you smoke? _____ Have you ever smoked? _____
If so, how many years? _____ How many packs per day? _____
Do you drink alcohol? _____ If so, how much & how often? _____
Have you ever used any illicit drugs (pot, XTC, cocaine)? _____
Have you ever had unprotected sex? _____

REVIEW OF SYSTEMS:

PLEASE PUT A CHECK NEXT TO ANY SYMPTOM YOU HAVE HAD RECENTLY

1 - GENERAL SYMPTOMS:

- Lost or gained more than 30lbs. in the past 6 months?
- Eating a lot
- Drinking a lot
- Having any bleeding problems
- Cold intolerance
- Fatigue
- Fever
- Heat intolerance
- Hot flashes
- Lethargy
- Night sweats
- Swollen glands
- Recent infection
- TB exposure
- Transfusions
- Trauma
- Weakness

2 - NEUROLOGICAL-PSYCHIATRIC:

- Head pain
- Clumsiness
- Confusion
- Double vision -
one eye; right or left
both eyes
- Disorientation
- Dizziness
- Falls
- Incoordination
- Memory Loss
- Numbness
- Paralysis
- Strange feelings over your body
- Seizures
- Speech Impairment
- Syncope
- Tremor
- Vertigo
- Agitation
- Anxiety
- Apathy
- Apprehension
- Depressed
- Hallucinations
- Insomnia
- Irritability
- Restlessness
- Suicidal Ideation

3 - HEAD, EYES, EARS, MOUTH, NOSE AND THROAT:

- Runny nose
- Dental or Teeth Problems
- Tooth pain
- Tongue pain
- Drooling
- Dry Mouth
- Pain or trouble with swallowing
- Pain or trouble with eating
- Facial Pain
- Do loud sounds bother you?
- Eye Pain
- Ear pain
- Oral Ulcerations
- Post Nasal Drainage
- Sinus Pain
- Ringing in ears
- Vision Impairment

4 - NECK:

- Hoarseness
- Neck Limited Motion
- Neck Pain
- Neck Swelling

5 - LUNGS:

- Cough
- Blood in sputum
- Shortness of breath
 - when sleeping
 - at rest
- Wheezing

6 - HEART:

- Chest Pain
- Murmur
- Palpitations

7 - GENITAL, URINARY, RECTAL AND BREAST:

- Breast Discharge
- Breast Mass
- Breast Pain
- Dark Urine
- Decreased Libido
- Dysuria
- Genital Ulcers
- Groin Pain

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- Blood in Urine
- Hemorrhoids
- Getting up at nighttime to urinate
- Pelvic Pain
- Urinating a lot during the day
- Rectal Pain
- Stool Incontinence
- Suprapubic Pain
- Urethral Discharge
- Urinary Incontinence
- Urinary Flow Slow
- Urinary Hesitancy
- Urinary Retention
- Urinary Urgency

Females:

Is your cycle

- irregular
- excessive bleeding
- painful
- Has it changed recently
- Are you pregnant?
- Vaginal Discharge
- Vaginal Irritation

Males:

- Impotence
- Scrotal Mass
- Testicle Pain

8 - BONES, JOINTS, EXTREMITIES AND MUSCULOSKELETAL:

- Painful joints
- Back Pain
- Leg swelling
- Heel Pain
- Hip Pain
- Joint Stiffness
- Joint Swelling
- Knee Pain
- Leg Pain
- Muscle Cramps
- Muscle Twitching
- Achy muscles
- Do your hands become blue when you reach into the freezer for something?

9 - ABDOMINAL AND GASTROINTESTINAL:

- Abdomen Pain
- Belching
- Constipation
- Diarrhea
- Flank Pain

- Flatulence
- Hernia
- Dark or bloody stools
- Nausea
- Vomiting

10 - SKIN:

- Tick bite
- Bruising
- Cysts
- Sweatiness
- Hair Problems
- Jaundice
- Mole Changes
- Itchiness
- Rash
- Skin Lesions

AUTHORIZATION AND RELEASE:

I AUTHORIZE THE RELEASE OF ANY INFORMATION, INCLUDING THE DIAGNOSIS AND RECORDS OF ANY TREATMENT OR EXAMINATION RENDERED TO ME DURING THE PERIOD OF SUCH CARE TO THIRD PARTY PAYERS, AND/OR OTHER HEALTH PRACTITIONERS. I AUTHORIZE AND REQUEST MY INSURANCE COMPANY TO PAY DIRECTLY TO THE DOCTOR ANY INSURANCE OTHERWISE PAYABLE TO ME.

FINANCIAL ARRANGEMENTS:

FOR YOUR CONVENIENCE, WE ACCEPT CASH AND PERSONAL CHECK TOWARD PAYMENT. PAYMENT IN FULL AT EACH APPOINTMENT IS REQUIRED, UNLESS OTHER ARRANGEMENTS ARE MADE. I UNDERSTAND THAT IF AN INSURANCE CLAIM IS DENIED, FOR ANY AND ALL SERVICES RENDERED TO ME (BASED ON ELIGIBILITY), BY MY INSURANCE CARRIER, I AM FINANCIALLY RESPONSIBLE FOR ANY CHARGES INCURRED.

PRINT NAME: _____

SIGNATURE: _____

DATE: _____