

Multiple Sclerosis Study Questionnaire

Case History

Date _____

Name _____ Birthdate _____
Last First Middle

Address _____
Street City State/Prov Zip/Post

Telephone: Home _____ Work _____ Email _____
With Area Code

Occupation _____

Referred by _____

Emergency Contact _____
Name Telephone Address

Please Answer the following questions to the best of your ability.

Where were you born?

Where did you spend your teen years?

When were you diagnosed with Multiple Sclerosis? What type do you have?

Who made the diagnosis, and how was the diagnosis arrived at?

What tests have been done? When and where were they done?

MS is a disease of cycles. Please indicate the duration of your cycles (lengths in days of months)of worsening symptoms (exacerbations) and reduction of symptoms (remissions). How has your disease progressed over time?

When was your worst symptom experience?

When was your best experience since your diagnosis?

On a scale of 1 to 10 of overall severity or impact on your life (1= No impact, 10= The worst your could imagine) Please rate the following:

<u>Symptom</u>	<u>Please circle one</u>
<u>Global impact of MS on your life</u>	1 2 3 4 5 6 7 8 9 10
<u>Gait disturbance (Problems with walking)</u>	1 2 3 4 5 6 7 8 9 10
<u>Problems with balance</u>	1 2 3 4 5 6 7 8 9 10
<u>Walk with assistance? (Cane, Walker)</u>	1 2 3 4 5 6 7 8 9 10
<u>Use a wheelchair? (How much time?)</u>	1 2 3 4 5 6 7 8 9 10
<u>Sensitivity to heat</u>	1 2 3 4 5 6 7 8 9 10
<u>Fatigue/ Energy level?</u>	1 2 3 4 5 6 7 8 9 10
<u>Cognitive performance? (Memory, Concentration)</u>	1 2 3 4 5 6 7 8 9 10
<u>Mood Swings (Irritability, Elation, depression)</u>	1 2 3 4 5 6 7 8 9 10
<u>Urinary Incontinence</u>	1 2 3 4 5 6 7 8 9 10
<u>Constipation</u>	1 2 3 4 5 6 7 8 9 10
<u>Difficulty in swallowing</u>	1 2 3 4 5 6 7 8 9 10
<u>Decreased sexual desire/ response</u>	1 2 3 4 5 6 7 8 9 10
<u>Muscle spasms/ Stiffness/ Spasticity</u>	1 2 3 4 5 6 7 8 9 10

<u>Double Vision</u>	1 2 3 4 5 6 7 8 9 10
<u>Nystagmus (Rapid Eye Movement)</u>	1 2 3 4 5 6 7 8 9 10
<u>Vertigo</u>	1 2 3 4 5 6 7 8 9 10
<u>Muscle Jerking/ Overactive Reflexes</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Arm Weakness</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Arm Weakness</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Arm Numbness</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Arm Numbness</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Arm Tingling</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Arm Tingling</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Leg Weakness</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Leg Weakness</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Leg Numbness</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Leg Numbness</u>	1 2 3 4 5 6 7 8 9 10
<u>Right Leg Tingling</u>	1 2 3 4 5 6 7 8 9 10
<u>Left Leg Tingling</u>	1 2 3 4 5 6 7 8 9 10
<u>Facial Numbness (Which Side?) Both?</u>	1 2 3 4 5 6 7 8 9 10
<u>Facial Pain (Tic Doloureux)</u>	1 2 3 4 5 6 7 8 9 10
<u>Other Pain (Feet/ Hands/ Arms/Legs/Back?)</u>	1 2 3 4 5 6 7 8 9 10

Past Medical History

Major Illness:

Hospitalizations/Surgeries- Please Give Month/Year if Possible:

Past Prescriptions and treatments for your Multiple Sclerosis- names and doses (any reactions?)

Allergies and Sensitivities-Foods, Environmental, etc.-Ever tested? Copies of reports?

Occupational Exposures

Vaccinations

- | | |
|--|---------------|
| <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetnus) | Year(s) _____ |
| <input type="checkbox"/> Booster (usually DT) | Year(s) _____ |
| <input type="checkbox"/> Polio injection <input type="checkbox"/> Polio oral | Year(s) _____ |
| <input type="checkbox"/> MMR(Measles, Mumps, Rubella) | Year(s) _____ |
| <input type="checkbox"/> HBV (Hepatitis B Vaccine) | Year(s) _____ |
| <input type="checkbox"/> Other | |

Did you have any illness, fever or other side effects after the vaccinations?

If you did have any reaction, do you know the batch and lot number of the vaccine used (old shot records)

Women Only: Last Pap_____ First day of Last Menstrual Period_____

Marital History: Years Married_____ # of Children _____ Ages_____

No. of Pregnancies_____ Deliveries_____ Complications_____

Use of Contraceptive?_____ What Type?_____

Lifestyle Factors- Please fill in the appropriate amounts:

	Never	Occasionally	Weekly	Daily
Coffee	_____			
Tobacco	_____			
Alcohol	_____			

Exercise Activities

	Never	Minutes	Hours	Daily	Weekly
Swim	_____				
Run	_____				
Walk	_____				
Dance	_____				
Bike	_____				
Garden	_____				
Weights	_____				
Golf	_____				
Other	_____				

Family History- Please see attached page

Dietary History- Please see attached page

Diet Log

Please write down what you eat and drink for a week! This includes juice, coffee, alcohol. If you're attempting to follow any particular diet, please indicate that in the space below the table, IE Swank diet, Atkins.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Breakfast							
Snack							
Lunch							
Snack							
Dinner							
Snack							

Family Medical History

Please give age, lists of any illness, or if deceased.
If deceased, list cause of death and age of death.

Mother: _____

Father: _____

Brothers and Sisters:

Mother's Parents:

Father's Parents: _____

Possibilities

- Allergies
- Alcoholism
- Asthma
- Bleeding Tendency

- Cancer-Type
- Chron's Disease
- Diabetes-Age at Onset
- Drug Abuse
- Epilepsy

- Gall Bladder
- Glaucoma
- Heart Disease-Type
- High Blood Pressure
- Hearing Loss
- Hypoglycemia
- Kidney Disease
- Liver Disease-Type

- Lupus
- Mental Illness- Type
- Multiple Sclerosis
- Rheumatoid Arthritis
- Thyroid Disease
- Tuberculosis
- Skin Disease-Type
- Other Conditions

Consent for Procarin Therapy for Multiple Sclerosis

Nature of Treatment

I understand that I am requesting to purchase for self use only, the Procarin therapy under the direction and care of my primary physician _____, with whom I have consulted regarding my use of Procarin therapy as a possible treatment of my disease, multiple sclerosis. I understand that I am purchasing this treatment under the direction of my primary physician who has written an "off label" prescription for my use of the compounded medications contained in the Procarin therapy for the treatment of multiple sclerosis.

I understand that the administration of the compounded medications contained in the Procarin therapy via a transdermal patch, subcutaneous injection, oral, or intravenous is not approved by the FDA as a treatment modality for Multiple Sclerosis. I understand that the safety, effectiveness, and tolerability of the Procarin therapy has not been yet determined.

Nevertheless, I have freely chosen to purchase and /or use the Procarin therapy. I understand I bear all risks associated with the use of this product.

Costs

I understand that I am responsible for the cost of the Procarin therapy. I understand that I am responsible for any costs incurred for any medical attention or treatment required as a result of my use of the Procarin therapy. I understand that the cost of this treatment may not be covered by my medical insurance nor may the cost of medical attention and treatment I may require in the event of an adverse reaction or side effect to the Procarin Therapy.

Risk of Treatment

1. Pain, tenderness, bruising, swelling, inflammation, or rash at the patch or injection sites.
2. Flushing, dizziness, headache, fainting, cyanosis (bluish coloring) of the face.
3. Hypo tension, hypertension pulse irregularities, rapid pulse, chest pains.
4. Dyspnea (difficult in breathing.)
5. Abdominal discomfort, nausea, vomiting, and diarrhea.
6. Increased urination.
7. Increase in symptoms of bursitis and tendonitis.
8. Burning or itching skin
9. Nervousness
10. Metallic taste
11. Blurred vision
12. Blood clots in arms or legs.
13. Severe allergic reaction that could result in shock, convulsions, and death.

I have chosen to purchase and /or use the Procarin therapy of my own free will, and I understand that I bear all risk associated with the use of this product. I agree to hold harmless EDMS, LLC, and any and all of its associates, and Key Pharmacy and any and all of its associates for any and all injury and incurred costs of such injury as a result of my use of the Procarin therapy. I authorize the release of medical information to EDMS consisting of my name, address, phone number, and prescriber for the medical purpose of studying the effects of Procarin therapy.

Date

Patient

Witness

Physician

Tacoma Clinic

Nutrition Center and Dispensary
801 Sw 16th Suite 121
Renton WA 98057
425-264-0059

Jonathan V. Wright, MD

Medical Director

Multiple Sclerosis Study Participation Using "Procarin"

It has always been the policy of the Tahoma Clinic to schedule a full hour appointment for each new patient attending our clinic. We believe that spending this time with you at the beginning of the treatment promotes the concepts of holistic medicine by establishing a meaningful patient to doctor relationship. This will allow you and your doctor adequate time to get to know each other, to ask important questions and consider the many options available for comprehensive medical treatment. For us, it is considered the standard of good medical practice.

To your health and wellness,

Jonathan V. Wright, MD