Multiple Sclerosis Center of California®
Daniel S. Bandari, M.D, Inc.

HEALTH QUESTIONNAIRE

Today's Date: _____

Name: _____**Date of Birth:** _____

Medical Condition/Reason for today's visit: _____

Past Medical History / Current Diagnosis (Check all that apply and list any pertinent information):

_____Multiple Sclerosis ____Transverse Myelitis ____Optic Neuritis ____Devic's Disease (NMO)

_____High Blood Pressure ____Diabetes (Type I or II) ____Thyroid dysfunction (Hyper / Hypo)

_____High Cholesterol _____Migraine _____Non Migraine Headache _____Celiac Disease

_____Rheumatologic Issues (RA, Lupus, Sjogren's…….) _____Spinal Stenosis/Disc problem

_____Cardiac issues _____Respiratory issues _____Gastrointestinal issues

_____Infections (Lyme, HSV I or II, Hep. B, Hep.C, HIV, Mono, Shingles, TB)

_____Other: _____

Prior Surgeries: _____

Current Symptoms: (Check all that apply and list any pertinent information):

___Numbness ____Weakness ____Walking / Gait problem ____Fatigue ____Visual Issues ___Imbalance

___Bladder issues ____Bowel issues ____Sexual issues ____Speech issues ____Swallowing issues

___Spasticity ____Vertigo/Dizziness ____Pain (location: _____) ____Foot drop

___Facial pain/numbness ___Memory / Cognitive issues ____Mood / Psychological issues

___ Other: _____

Current Medications:
(Please provide a medication list separately or below and include dose and frequency as well as over the counter medication and vitamins). If you need more space, please write them on the back of this page.

Name	Dose & frequency	Name	Dose & frequency

Patient's Name_____

Local Pharmacy (name, address and phone number):

_____

Mail Order Pharmacy (name, address and phone number):

_____

Drug Allergies: _____

Mobility: (Check all that apply)

____ No assistive devices (and planning to stay like this☺)

____Cane _____Walker ____Scooter _____ Wheelchair (Manual/Electric) ____Other _____

Do you **Smoke**? ___Yes ___ No, If yes, how many years? _____ Quantity? _____

When did you stop smoking? _____

Do you drink **alcohol**? If yes, what type? _____ Frequency? _____

Do you drink caffeine? _____ if yes, how many cups a day? _____

Family History (Please mark all that apply):

Condition	Relationship	Condition	Relationship
___Multiple Sclerosis	_____	___ Cardiac issues	_____
___Cancer/Malignancy	_____	___Stroke	_____
___ Migraine	_____	___Alzheimer's Disease	_____
___ Parkinson's disease	_____	___Autoimmune Disorders	_____

___ Other Neurologic diseases _____

___Other_____

Date of the most recent MRIs:

Brain_____ C-Spine_____ T-Spine_____ Other_____

*(Please obtain a copy of your films/discs and the reports and bring to your appointment)

Previous Multiple Sclerosis Medications / Treatments/ Procedures: (Please list ALL the names and duration)

Name: Medication /Procedure	Duration/ Date