Pre Visit Question/Interview Template Patient's Name _____

1. DOB and age? _____
2. Ht/Wt/Allergies/R or L handed? _____
3. Can the patient tolerate lying on their back to have procedure done? _____
4. Have you had any recent labs? _____
5. Do you have a list of current medications? _____
6. What are your symptoms? When did they first start? _____
7. When were you first diagnosed? What type of MS do you have? _____
8. Do you have slowed thinking or "mental fog"? _____
9. Do you have an inability to concentrate? _____
10. Do you have problems with memory? _____
11. Are you fatigued? How much does it affect your daily life/or bring your energy down? (0-10) _____
12. Do you have loss of balance/coordination? _____
13. Do you have numbness/tingling? Upper or Lower Extremities? _____
14. Do you have loss of bowel/bladder function? Constipation? Diarrhea? _____
15. Do you have any blindness/blind spots/ sensitivity to light? _____
16. Have you had any difficulty swallowing or slurred speech? _____
17. Are you or have you been depressed? _____

18. Do you have heat intolerance? _____

19. Do you have any pain? If so, describe. _____
_____

20. Have your symptoms been coming and going? If so, how long do they last and how much time in between episodes? _____
_____
_____

21. Do you have any history of GI Bleeding or ulcers? Any history of thrombosis or blood clots? _____

22. Who is your family physician? Address/Phone number? _____
_____

23. Who is your neurologist? Address/Phone number? _____
_____

24. Exclusion Criteria: Pacemaker/implantable device? _____

Surgery for aneurysm? _____

Metal fragments in or near eye? _____

Claustrophobia? _____

Serum creatinine > 1.8 mg/dl? _____

History of kidney problems? _____

Pregnant? _____

CCSVI Intake

Patient Name: _____

Date: ____ /____ /_____

Date of Birth	____ /____ /_____
Gender (circle one)	***Male*** ***Female***
Handedness (circle one)	***Right / Left / Ambidextrous***
Highest education level	
Ethnicity	
Email address	
Current Medications	
*Please **list** the Medications you take to control potentially CCSVI related condition*	
*Please **list** the psychotropic medications you take* *(anti-anxiety and/or anti-depressant and/or mood stabilizing)*	
*Please **list** any other medications*	
Medical History	
History of Head Trauma or Loss of Consciousness.	☐ ***Yes*** ☐ ***No*** *Date(s)* *Description:*

Patient ID: _____

History of psychiatric or psychological diagnosis and/or treatment.	☐ ***Yes*** ☐ ***No*** *Date(s)* *Description of specific diagnosis and treatment:*
What potentially CCSVI related diagnosis do you have?	*CCSVI Diagnosis: MS____ Other:_____* *Date of First Symptom: _____* *Date you were first diagnosed:_____*
Have you had previous CCSVI Testing?	*CCSVI Testing:* ☐ ***Yes*** ☐ ***No*** *Describe Testing:* *CCSVI Testing Date: _____*
Have you had previous CCSVI Treatment?	*CCSVI Treatment: :* ☐ ***Yes*** ☐ ***No*** *Describe Treatment:* *CCSVI Treatment Date: _____* *Treating Physician Name: _____*
Diagnosed with MS?	☐ ***Yes*** *(circle subtype below)* ☐ ***No*** *Primary Progressive* *Secondary Progressive* *Relapsing-remitting*
Within the last 12 months:	
How many times have you been admitted to the Emergency Room?	☐ ***Yes*** *(times_____)* ☐ ***No*** *Reason for Admittance:*

Patient ID: _____

How many Doctor Visits (within the last 12 months) have you attended?	☐ **Yes** (times_____) ☐ **No** Date: Specialty of Physician: _____ Date: Specialty of Physician: _____ Date: Specialty of Physician: _____ Date: Specialty of Physician: _____ Date: Specialty of Physician:
Medical Status	
Please **list** history of any surgeries or hospitalizations:	
Are you on disability?	☐ **Yes** ☐ **No**
If yes, date disability was diagnosed:	
Who gave you this disability diagnosis?	
If you have been given an EDSS score by a neurologist, what score were you given?	
What date was this EDSS score given to you?	

SF-36 v2™ Health Survey

(SF-36 v2 Standard, US Version 2.0)

To be completed by the PATIENT

Name (Last, First, Middle Initial)
Identification Number
Event

Directions: *Answer every question by filling in the correct circle or writing in the information. If you need to change an answer, completely erase the incorrect mark and fill in the correct circle. If you are unsure about how to answer a question, please give the best answer you can.* **Mark only one answer for each question unless instructed otherwise.**

Today's Date (MM/DD/YY)
☐☐ / ☐☐ / ☐☐

Shade circles like this: ● **Not like this:** ⊗ ✓

Mark only one answer for each question. Please do not mark outside the circles or make stray marks on the questionnaire.

01. In general, would you say your health is:

○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor

02. Compared to one year ago, how would you rate your health in general now?

○ Much better ○ Somewhat better ○ About the same ○ Somewhat worse ○ Much worse

The following questions are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?	Yes, limited a lot	Yes, limited a little	No, not limited at all
03. Vigorous activities, such as running, lifting heavy objects, participating in strenuous sports	○	○	○
04. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	○	○	○
05. Lifting or carrying groceries	○	○	○
06. Climbing several flights of stairs	○	○	○
07. Climbing one flight of stairs	○	○	○
08. Bending, kneeling, or stooping	○	○	○
09. Walking more than a mile	○	○	○
10. Walking several hundred yards	○	○	○
11. Walking one hundred yards	○	○	○
12. Bathing or dressing yourself	○	○	○

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of your physical health?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
13. Cut down on the amount of time you spent on work or other activities	○	○	○	○	○
14. Accomplished less than you would like	○	○	○	○	○
15. Were limited in the kind of work or other activities	○	○	○	○	○
16. Had difficulty performing the work or other activities (for example, it took extra effort)	○	○	○	○	○

Please continue on next page

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Patient Last Name: _____

During the past 4 weeks, how much of the time have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?	All of the time	Most of the time	Some of the time	A little of the time	None of the time
17. Cut down the amount of time you spent on work or other activities	○	○	○	○	○
18. Accomplished less than you would like	○	○	○	○	○
19. Did work or activities less carefully than usual	○	○	○	○	○

20. During the past 4 weeks, to what extent has your physical health or emotional problems interfered with your normal social activities with family, friends, neighbors, or groups?

○ Not at all ○ Slightly ○ Moderately ○ Quite a bit ○ Extremely

21. How much bodily pain have you had during the past 4 weeks?

○ None ○ Very mild ○ Mild ○ Moderate ○ Severe ○ Very severe

22. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks...	All of the time	Most of the time	Some of the time	A little of the time	None of the time
23. Did you feel full of life?	○	○	○	○	○
24. Have you been very nervous?	○	○	○	○	○
25. Have you felt so down in the dumps that nothing could cheer you up?	○	○	○	○	○
26. Have you felt calm and peaceful?	○	○	○	○	○
27. Did you have a lot of energy?	○	○	○	○	○
28. Have you felt downhearted and depressed?	○	○	○	○	○
29. Did you feel worn out?	○	○	○	○	○
30. Have you been happy?	○	○	○	○	○
31. Did you feel tired?	○	○	○	○	○
32. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting friends, relatives, etc.)?	○	○	○	○	○

How TRUE or FALSE is each of the following statements for you?	Definitely true	Mostly true	Don't know	Mostly false	Definitely false
33. I seem to get sick a little easier than other people	○	○	○	○	○
34. I am as healthy as anybody I know	○	○	○	○	○
35. I expect my health to get worse	○	○	○	○	○
36. My health is excellent	○	○	○	○	○

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