PATIENT IDENTITY

NAME: _____ Birth date: Day ___ Month ___ Year _____

First name: _____ ○ Male ○ Female

Birth name: _____

Addresses

Patient	*Postal address*	
	Tel./fax	*E-mail*
Family doctor	*Postal address*	
	Tel./fax	*E-mail*
Neurologist	*Postal address*	
	Tel./fax	*E-mail*

BACKGROUND

Height (cm): _____ ○ Right-handed Patient knowledge of the diagnosis: ○ No ○ Yes

Weight (kg): _____ ○ Left-handed

○ Ambidextrous Date of the first exam in the department: ___ ___ _____

Job title

Particular form of MS

○ None ○ Marburg variant

○ Acute disseminated encephalo-myelitis ○ Balo's concentric sclerosis

○ Transverse myelitis ○ Schilder's disease

○ Devic's disease ○ Other, specify: _____

Family

Size of patient's sibship: Rank of patient in sibship: _____

The patient is a twin: ○ No ○ Yes ..... Specify: ○ Monozygote ○ Dizygote

The patient is caucasoid: ○ No ○ Yes ..... If no, specify: _____

			Family member:	*Confirmed by neurologist:*
Familial MS:	○ No	○ Yes ..... Specify:	_____	☐
			_____	☐
Number of children of the patient:	Boys	_____	_____	☐
	Girls	_____	_____	☐
	Total	_____	_____	☐

Other diseases ***Patient*** ***Patient's family***

☐ Tobacco

☐ Alcohol

☐ Other toxic _____

	May interfere with MS-related disability:
☐ Auto-immune disease	☐
☐ Hypertension	☐
☐ Migraine	☐
☐ Cancer	☐
Other: _____	☐
_____	☐
_____	☐
_____	☐

Family member:	*Disease:*
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____