Form filled by: Validated by:

| PATIENT IDENTITY  |   |                                |   |              |                 |                           |
|---|---|--------------------------------|---|--------------|-----------------|---------------------------|
| NAME:   |   |                                | B <sup>;</sup>  | irth date:   | Day Month Y     | /ear                      |
| First name:   |   |                                |   | ) Male       | O Female        |                           |
| Birth name:   |   |                                |   |              |                 |                           |
|   | _   | _                              | _   |              |                 |                           |
| Addresses Patient   | Postal address  |                                |   |              |                 |                           |
| Falletill   | Tel./fax  |                                |   | E-mail       |                 |                           |
| Family doctor   | Postal address  |                                |   |              |                 |                           |
|   | Tel./fax  |                                |   | E-mail       |                 |                           |
| Neurologist   | Postal address  |                                |   | - mail       |                 |                           |
|   | Tel./fax  |                                |   | E-mail       |                 |                           |
|   |   | BACKGF                         | ROUND   |              |                 |                           |
| Height (cm):  | <ul><li>Right-handed</li><li>Left-handed</li><li>Ambidextrous</li></ul> | Patient kı                     | nowledge of the   |              | tment:          | Yes                       |
| Job title   |   |                                |   |              |                 |                           |
|   |   |                                |   |              |                 |                           |
| Particular form of MS   |   |                                |   |              |                 |                           |
| <ul><li>None</li><li>Acute disseminated</li><li>Transverse myelitis</li><li>Devic's disease</li></ul> |   | O Balo                         | burg variant<br>o's concentric s<br>ilder's disease<br>er, specify: | sclerosis    |                 |                           |
| Family  |   |                                |   |              |                 |                           |
| Size of patient's si  | bship:  |                                | Rank  | k of patient | in sibship:     | I                         |
| The patient is a  |   | 'es                            |   | O Monoz      |                 |                           |
| The patient is cauc   | asoid: O No O Y   | es If n                        | io, specify:  |              |                 | 0                         |
| Famili  | al MS: O No O Y   | ⁄es                            | . Specify:  | <u></u>      | Family member:  | Confirmed by neurologist: |
| Number of children of the p   | oatient: Boys<br>Girls<br>Total   |                                |   |              |                 |                           |
| Other diseases  | Patient   |                                | _   | Pa           | atient's family |                           |
| Tobacco   | rauent  |                                |   | <i>1</i> - u | luent's ranny   |                           |
| ☐ Alcohol ☐ Other toxic   | May in:<br>MS-relat   | terfere with<br>ed disability: | Family me   | ember:       | Disease:        |                           |
| Auto-immune disea   | se  |                                | ]   |              | <u> </u>        |                           |
| ☐ Hypertension☐ Migraine  |   |                                |   |              |                 |                           |
| ☐ Cancer  |   |                                |   |              |                 |                           |
| Other:  |   |                                | <u> </u>  |              | <u> </u>        |                           |
|   |   |                                |   |              |                 |                           |
|   |   |                                |   |              |                 |                           |

| Name, first name:  | Form filled by:   |
|--|---|
| Birth date:  | Validated by:   |
| SOCIOFEC   | CONOMICS  |
| Education  | Marital status  |
| ☐ Elementary school ☐ Secondary school ☐ University bachelor ☐ University master ☐ University doctorate  | <ul><li>Single</li><li>Married / living with partner</li><li>Divorced / separated</li><li>Widowed</li></ul>   |
| Employment status  | Domestic status   |
| <ul> <li>Employed outside home</li> <li>Employed at home</li> <li>Homemaker</li> <li>Student</li> <li>Worker's compensation</li> <li>Unemployed looking for work</li> <li>Unemployed not looking for work</li> <li>Disabled under age 60</li> <li>Disabled over age 60</li> <li>Retired, not disabled under age 60</li> <li>Retired, not disabled over age 60</li> </ul> | ☐ Alone ☐ With spouse / partner ☐ With sibling ☐ With children ☐ With parent ☐ With other relative ☐ With friend / companion ☐ Domestic help ☐ Health-related companion ☐ Nursing or sheltered home |
| Worktime   |   |
| O Full time O Reduced hours O Adapted work   |   |
| COMMENTS   |   |

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| NEUROLOGICAL EPISODES   |                     |                                |  |                    |              |  |
|---|---------------------|--------------------------------|--|--------------------|--------------|--|
| Relapsing-remitting phase ——  | Progressive phase — |                                |  |                    |              |  |
| (A) 1st relapse (B) Subsequent relapse  | (C) Onset           | or without inaugural relapse / | / ( <b>D</b> ) Onset with inaugural re | elapse (E) Subsequ | uent relapse |  |
| Date of onset of the episode Day Month Year Doubtful date and/or number of episodes | MS onset            |                                |  |                    |              |  |
| Type of the episode (cf. classification above)                                      |                     |                                |  | Ш                  |              |  |
| Semeiology of the episode   |                     |                                |  |                    |              |  |
| Unknown   |                     |                                |  |                    |              |  |
| Walking difficulties  |                     |                                |  |                    |              |  |
| Lower extremity dysfunction   | 1 🗆                 |                                |  |                    |              |  |
| Upper extremity dysfunction   | ] 🗖                 |                                |  |                    |              |  |
| Sensory symptoms (pain, paresthesia, Lhermitte)                                     | ] 🗖                 |                                |  |                    |              |  |
| Bladder / bowel dysfunction   | ] 🗖                 |                                |  |                    |              |  |
| Sexual dysfunction  |                     |                                |  |                    |              |  |
| Oculomotor impairment   |                     |                                |  |                    |              |  |
| Facial motor  |                     |                                |  |                    |              |  |
| Facial sensory  |                     |                                |  |                    |              |  |
| Vertigo, hypoacousia  |                     |                                |  |                    |              |  |
| Speech / swallowing impairment  |                     |                                |  |                    |              |  |
| Reduced visual acuity (optic neuritis)  |                     |                                |  |                    |              |  |
| Mental deterioration  |                     |                                |  |                    |              |  |
| Psychiatric symptoms  |                     |                                |  |                    |              |  |
| Paroxysmal symptoms   |                     |                                |  |                    |              |  |
| Fatigue   |                     |                                |  |                    |              |  |
| Other   |                     |                                |  |                    |              |  |
| Features of the episode   |                     |                                |  |                    |              |  |
| Symptoms New / Recurring / Preexisting  |                     |                                |  |                    |              |  |
| Associated event No / Yes   | 0-0                 | 0-0                            | $\bigcirc$                             | 0-0                | 0-0          |  |
| If yes: trauma / stress / infection / vaccination / pregnancy                       | 00000               | 0-0-0-0                        | 0                                      | 0-0-0-0            | 00000        |  |
| Other, specify  |                     |                                |  |                    |              |  |
| Severity Mild / Moderate / Severe   | 0-0-0               | 0-0-0                          | 0-0-0                                  | 0-0-0              | 0-0-0        |  |
| Recovery Complete / Incomplete / None   | 0-0-0               | 0-0-0                          | 0-0-0                                  | 0-0-0              | 0-0-0        |  |
| Certainty Possible / Probable / Definite  | 0-0-0               | 0-0-0                          | 0-0-0                                  | 0-0-0              | 0-0-0        |  |
| Hospitalization No / Yes  If yes, duration in days                                  | 0—0                 | 0—0                            | O—O                                    | 0—0                | O—O          |  |
| Corticosteroid No / Yes treatment If yes, i.v. / i.m. / oral                        | 0-0-0               | 0 <u> </u>                     | 0—0<br>0-0-0                           | 0—0<br>0-0-0       | 0—0<br>0-0-0 |  |

| HISTORY OF IRREVERSIBLE DISABILITY (EDMUS Grading Scale)  |       |      |  |  |  |
|---|-------|------|--|--|--|
| Score (WD = walking distance):  | Month | Year |  |  |  |
| 1 No disability. Minimal signs on neurological examination.                                       |       |      |  |  |  |
| 2 Minimal and not ambulation-related disability. Able to run.                                     |       |      |  |  |  |
| 3 Unlimited WD without rest but unable to run; or a significant not ambulation-related disability | []    |      |  |  |  |
| 4 Walks without aid; limited WD but > 500 meters without rest.                                    |       |      |  |  |  |
| 5 Walks without aid; WD < 500 meters without rest.  |       |      |  |  |  |
| 6 A Walks with constant unilateral support. WD < 100 meters without rest.                         |       |      |  |  |  |
| 6 B Walks with constant bilateral support. WD < 100 meters without rest.                          |       |      |  |  |  |
| 7 Home restricted. A few steps with wall or furniture assistance. WD < 20 meters without rest     | L     |      |  |  |  |
| 8 Chair restricted. Unable to take a step. Some effective use of arms.                            | L     |      |  |  |  |
| 9 Bedridden and totally helpless.   |       |      |  |  |  |
| 10 Death  | 📖     |      |  |  |  |
| Due to MS: O Yes O No, specify:   |       |      |  |  |  |
| Pathological verification: O No O Yes, specify:   |       |      |  |  |  |

| HISTORY OF DIAGNOSIS CRITERIA (dates of first positivity) |               |                                      |       |      |  |  |  |
|---|---------------|--------------------------------------|-------|------|--|--|--|
|   |               | Day                                  | Month | Year |  |  |  |
|   | Brain         | Paty criteria                        |       | ш    |  |  |  |
|   |               | Barkhof criteria                     | ш     | ш    |  |  |  |
| MRI   | Spinal cord   | Cervical                             |       | ш    |  |  |  |
|   |               | Thoracolumbar                        |       | ш    |  |  |  |
|   | New lesion(s) | (according to McDonald criteria)     |       |      |  |  |  |
| CEREBRO-SPINAL FLUID                                      |               | (IgG index and/or oligoclonal bands) | ш     | ш    |  |  |  |
|   |               | Visual                               |       | ш    |  |  |  |
| EVOKED POTENTIALS   |               | Brainstem auditory                   |       | ш    |  |  |  |
|   |               | Somatosensory                        |       | ш    |  |  |  |
|   |               | Motor                                | Ш     | Ш    |  |  |  |

| DIFFERENTIAL DIAGNOSIS         |                           |                     |  |  |  |  |  |
|--------------------------------|---------------------------|---------------------|--|--|--|--|--|
|                                | Unknown / Normal / Abnorm | al Value / Comments |  |  |  |  |  |
| Erythrocyte sedimentation rate |                           |                     |  |  |  |  |  |
| C-reactive protein             | <del>```</del>            |                     |  |  |  |  |  |
| Antinuclear antibodies         | ~ ~ ~                     |                     |  |  |  |  |  |
| Organ-specific antibodies      | $\sim$                    |                     |  |  |  |  |  |
| HIV                            | 9 9                       |                     |  |  |  |  |  |
| Borellia burgdorferi           |                           |                     |  |  |  |  |  |
| _                              | <b>~</b> ~ ~              |                     |  |  |  |  |  |
| HTLV 1 & 2                     |                           |                     |  |  |  |  |  |
| VDRL & TPHA                    |                           |                     |  |  |  |  |  |
| Very long chain fatty acids    | 0 0                       |                     |  |  |  |  |  |
| Lactic/pyruvic acids           | 0—0—0                     |                     |  |  |  |  |  |
| Lysosomal/peroxysomal enzymes  | ······ O—O—O              |                     |  |  |  |  |  |
| Vitamin B12                    | Ŏ—Ŏ—Ŏ                     |                     |  |  |  |  |  |
| Angiotensin converting enzyme  | <u> </u>                  |                     |  |  |  |  |  |

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|           | HISTORICAL OVER               | VIEW OF DISEASE-N                | MODIFYING TREATMENTS  |         |
|-----------|-------------------------------|----------------------------------|---|---------|
|           |                               |                                  | Reason for stopping   | Comment |
| Drug name | Date of start  Day Month Year | Date of stopping  Day Month Year | Reason for stopping  Scheduled stop Lack of tolerance (local) Lack of tolerance (general) Lack of tolerance (biological) Lack of efficacy Patient's convenience Serious adverse event I Other |         |
|           |                               |                                  |   |         |
|           |                               |                                  |   |         |
|           |                               |                                  |   |         |
|           |                               |                                  | 0000000   |         |
|           |                               |                                  |   |         |
|           |                               |                                  | 0000000   |         |
|           |                               |                                  | 0000000   |         |
|           |                               |                                  |   |         |
|           |                               |                                  | 00000000  |         |
|           |                               |                                  | 0000000   |         |
|           |                               |                                  |   |         |
|           |                               |                                  |   |         |
| COMMENTS  |                               |                                  |   |         |