Form filled by:
Validated by:

PATIENT IDENTITY

NAME:
First name:
Birth name:
Birth date: Day Month Year
○ Male ○ Female

Address

Postal code:
Phone/Fax::
E-mail:

BACKGROUND & SOCIO-ECONOMICS

Size (cm) :
Weight (kg) :
○ Right-handed
○ Left-handed
○ Ambidextrous
Patient knowledge of the diagnosis: ○ No ○ Yes
Date of first exam in the department: Day Month Year

Domestic status

○ Alone
○ With spouse or companion
○ With other relative(s)
○ Nursing or sheltered home

Employment status

○ Employed, full-time (incl. students)
○ Employed, worktime reduced
○ Unemployed due to MS
○ Homemaker
○ Other (child, retired, looking for work)

Job title

Particular form of MS

○ None
○ Acute disseminated encephalomyelitis
○ Balo concentric sclerosis
○ Devic disease
○ Marburg variant
○ Transverse myelitis
○ Schilder disease
○ Other, specify:

Family

Size of patient's sibship:
Rank of patient in sibship:
The patient is a twin: ○ No ○ Yes ..... Specify: ○ Monozygotic ○ Dizygotic
The patient is caucasoid: ○ No ○ Yes ..... If no, specify:
Familial MS : ○ No ○ Yes ..... Specify:

Number of patient's children:
Boys
Girls
Total

Family member:	*Confirmed by neurologist:*
	☐
	☐
	☐
	☐
	☐

Other diseases ***Patient***

☐ Tobacco ☐ Other toxic:
☐ Alcohol

May interfere with MS-related disability:

☐ Auto-immune disease
☐ Hypertension
☐ Migraine
☐ Cancer
Other:

Patient's family

Family member:	*Disease:*

COMMENTS

HISTORY OF IRREVERSIBLE DISABILITY (EDMUS Grading Scale)

Score (WD = walking distance):	Date: 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.		
8 Chair restricted. Unable to take a step. Some effective use of arms.		
9 Bedridden and totally helpless.		
10 Death		

Due to MS: ○ Yes ○ No, specify: ....

Pathological verification: ○ No ○ Yes, specify: ....

HISTORY OF DIAGNOSIS CRITERIA (dates of first positivity)

			Day	Month	Year
M R I	**Brain**	*Paty criteria*			
		Barkhof criteria			
	Spinal cord	*Cervical*			
		Thoracolumbar			
	New lesion(s)	(according to McDonald criteria)			
CEREBRO-SPINAL FLUID		*(IgG index and/or oligoclonal bands)*			
EVOKED POTENTIALS		*Visual*			
		Brainstem auditory			
		Somatosensory			
		Motor			

DIFFERENTIAL DIAGNOSIS

	Unknown / Normal / Abnormal	Values / Comments
Erythrocyte sedimentation rate	○—○—○	
C-reactive protein	○—○—○	
Antinuclear antibodies	○—○—○	
Organ-specific antibodies	○—○—○	
HIV	○—○—○	
Borellia burgdorferi	○—○—○	
HTLV 1 & 2	○—○—○	
VDRL & TPHA	○—○—○	
Very long chain fatty acids	○—○—○	
Lactic/pyruvic acids	○—○—○	
Lysosomal/peroxysomal enzymes	○—○—○	
Vitamin B12	○—○—○	
Angiotensin converting enzyme	○—○—○	

HISTORICAL OVERVIEW OF DISEASE-MODIFYING TREATMENTS

Drug name	**Date of start** Day Month Year	**Date of stopping** Day Month Year	Scheduled stop / Local intolerance / General intolerance / Biological intolerance	Inefficacy / Patient's convenience / Serious adverse event / Other	**Reason for stopping Comments**
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	
			□□□□	□□□□	

Name, first name: Form filled by:

Birth date: Validated by:

NEUROLOGICAL EPISODES

Relapsing-remitting phase

*(**A**) 1st relapse*

*(**B**) Subsequent relapse*

Progressive phase

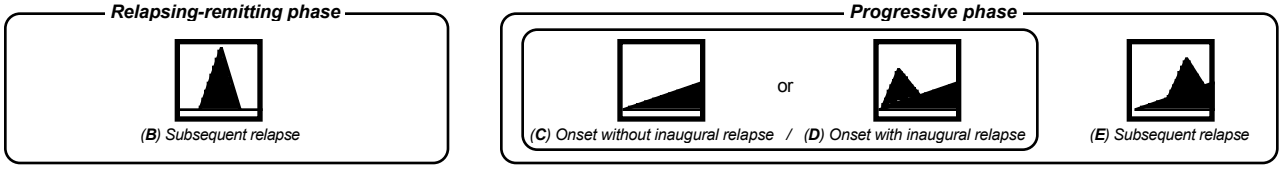
or

*(**C**) Onset without inaugural relapse / (**D**) Onset with inaugural relapse*

*(**E**) Subsequent relapse*

		MS Onset				
Date of onset of the episode	*Day*	☐☐	☐☐	☐☐	☐☐	☐☐
	Month	☐☐	☐☐	☐☐	☐☐	☐☐
	Year	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐	☐☐☐☐
	Doubtful date and/or number of episodes	☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Episode type	*(cf. classification above)*	☐	☐	☐	☐	☐
Semiology of the episode						
Unknown		☐	☐	☐	☐	☐
Walking difficulties		☐	☐	☐	☐	☐
Lower extremity dysfunction		☐	☐	☐	☐	☐
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		☐	☐	☐	☐	☐
Episode features						
Symptoms	*New / Recurring / Preexisting*		☐☐☐	☐☐☐	☐☐☐	☐☐☐
Associated event	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes: trauma / stress / infection / vaccination / pregnancy	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○
	Other, specify	____	____	____	____	____
Severity	*Mild / Moderate / Severe*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Recovery	*Complete / Incomplete / None*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Certainty	*Possible / Probable / Definite*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Hospitalization	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes, duration in days	____	____	____	____	____
Corticosteroid treatment	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes, i.v. / i.m. / per os	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○

NEUROLOGICAL EPISODES (continued)



Date of onset of the episode	*Day*					
	Month					
	Year					
	Doubtful date and/or number of episodes	☐ ☐	☐ ☐	☐ ☐	☐ ☐	☐ ☐
Episode type	*(cf. classification above)*					
Semiology of the episode						
Unknown		☐	☐	☐	☐	☐
Walking difficulties		☐	☐	☐	☐	☐
Lower extremity dysfunction		☐	☐	☐	☐	☐
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		☐	☐	☐	☐	☐
Episode features						
Symptoms	*New / Recurring / Preexisting*	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐	☐ ☐ ☐
Associated event	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes: trauma / stress / infection / vaccination / pregnancy	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○	○-○-○-○-○
	Other, specify					
Severity	*Mild / Moderate / Severe*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Recovery	*Complete / Incomplete / None*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Certainty	*Possible / Probable / Definite*	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○
Hospitalization	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes, duration in days					
Corticosteroid treatment	*No / Yes*	○—○	○—○	○—○	○—○	○—○
	If yes, i.v. / i.m. / per os	○-○-○	○-○-○	○-○-○	○-○-○	○-○-○