3. Date of Birth (mm/dd/yyyy) **City/Town of Birth** **State of Birth** **Country of Birth (if not USA)**

__/__/____ _____ ____ _____

Did you move out of state prior to age 15? If so, indicate to which state

a. State ____ **Age** ____ **b. State** ____ **Age** ____ **c. State** ____ **Age** ____

d. State ____ **Age** ____ **e. State** ____ **Age** ____ **f. State** ____ **Age** ____

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6. Ethnicity/Ancestry (15 largest categories, per US Census Bureau)

○ African American	○ English	○ Italian	○ Scotch-Irish
○ American	○ French	○ Mexican	○ Scottish
○ American Indian	○ German	○ Norwegian	○ Swedish
○ Dutch	○ Irish	○ Polish	○ Other

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16. Did you have exposure to the following risk factors before the onset of your disease (i.e., within 2 years)?

Fracture ○ Yes ○ No
Contact with dogs* ○ Yes ○ No
Contact with cats* ○ Yes ○ No
Contact with birds* ○ Yes ○ No
Spinal cord trauma ○ Yes ○ No
General anesthesia ○ Yes ○ No

*** Refers to frequent handling of animal and/or its feces**

Continual exposure to any chemical for over 1 year ○ Yes ○ No

Estimate your sun exposure (hours/day)

Winter ○ Less than 1 ○ 1-3 hours ○ 3+ hours
Summer ○ Less than 1 ○ 1-3 hours ○ 3+ hours

Smoking ○ Yes ○ No **No. of Years** ____ **Packs per day:** ○ 1 ○ 2 ○ 3 ○ 4 ○ 5+

17. Indicate if you had any of the following immunizations or the illness in the past

	Immunizations	Illness
Measles	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
German Measles	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Mumps	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Polio (oral)	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Polio (injection)	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Diphtheria	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Pertussis (Whooping Cough)	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Tetanus	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Mumps	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Chicken Pox	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Hepatitis B	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Hepatitis A	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall
Smallpox	○ Yes ○ No ○ Unknown/Can't Recall	○ Yes ○ No ○ Unknown/Can't Recall

27. Symptomatology of the episode:

	MS Onset (mm/yyyy)	MS Diagnosis (mm/yyyy)
Unknown	__/____	__/____
Walking Difficulties	__/____	__/____
Upper Extremity Dysfunction	__/____	__/____
Lower Extremity Dysfunction	__/____	__/____
Paroxysmal/sensory symptoms (pain, paresthesia, Lhermitte)	__/____	__/____
Bladder/bowel/sexual dysfunction	__/____	__/____
Vertigo/hypoacusia (hearing loss)	__/____	__/____
Speech/swallowing impairment	__/____	__/____
Oculomotor impairment	__/____	__/____
Facial motor/sensory	__/____	__/____
Mental deterioration/psychiatric symptoms	__/____	__/____
Fatigue	__/____	__/____
Optic Neuritis	__/____	__/____
Other	__/____	__/____