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Confirmation of Consent (to be completed by interviewer)

I confirm that the participant has signed the informed consent.

Interviewer Name

MM/DD/YYYY

Case Inclusion Criteria - Must be "Yes"

1. Individuals with at least one CNS demyelinating event characteristic of MS, TM, ADEM, NMO, ON or CIS. A demyelinating event is defined as a symptom or constellation of symptoms referable to the disruption of the CNS white matter or myelin within gray matter. Characteristic syndromes include hemibody sensory or motor symptoms, mono-sensory symptoms, monoparesis, brainstem syndrome or cerebellar syndrome, lasting at least 24 hours. No Yes
2. Individuals at least 18 years old and able to give informed consent or individuals younger than 18 years old, with parental permission, and able to give assent. No Yes
3. Individuals at least 18 years old willing and able to provide up to 110 ml blood via venipuncture or individuals younger than 18 years old willing and able to provide up to 50 ml blood via venipuncture. No Yes

Case Exclusion Criteria - Must be "No"

1. Individuals who weigh less than 37 pounds due to limits on blood collection. No Yes

Control Inclusion Criteria - Must be "Yes"

1. Related and unrelated individuals who have not experienced any CNS demyelinating events characteristic of MS, TM, ADEM, NMO, ON or CIS and have not been diagnosed with any demyelinating disease. No Yes
2. Individuals at least 18 years old and able to give informed consent or individuals younger than 18 years old, with parental permission, and able to give assent. No Yes
3. Individuals at least 18 years old willing and able to provide up to 110 ml blood via venipuncture or individuals younger than 18 years old willing and able to provide up to 50 ml blood via venipuncture. No Yes

Control Exclusion Criteria - Must be "No"

1. Individuals who weigh less than 37 pounds due to limits on blood collection. No Yes



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Laboratory Assessment

Do you have a history of blood borne pathogens (e.g., Hepatitis, HIV/AIDS)? Yes No

If so, we may not be able to collect your blood sample due to laboratory restrictions.

Have you had an allogenic bone marrow transplant since your last blood sample collection? Yes No

If so, we will be able to collect your blood sample but may not be able to use it for genetic analysis.

Has the participant been diagnosed with a stroke, meningitis, neoplastic, peripheral nervous system or primary muscle disease, or other well characterized and defined disease of the nervous system with the exception of MS, TM, ADEM, NMO, ON or CIS since the last study visit? Yes No

If yes, specify diagnosis: Date of diagnosis:
MM/DD/YYYY

Date of blood draw Time of blood draw
MM/DD/YYYY HH:MM

When was the last time the participant had something to eat or drink besides water?

HH:MM MM/DD/YYYY

When was the last time the participant smoked? Not applicable
HH:MM MM/DD/YYYY

Has the participant had any medications today (including birth control, vitamins, aspirin, etc.)? Yes No

If yes, specify medication names:

Within the last two weeks, when did the participant last have a dose of non-MS (TM, ADEM, NMO, ON) related medication (prescription or OTC)? Not applicable
MM/DD/YYYY

Specify medication name(s):

When did the participant last have a dose of MS (TM, ADEM, NMO, ON) related drug? Not applicable
MM/DD/YYYY

Specify medication name(s):

Has the participant had any immunizations in the last year (including flu shot)? Yes No Don't know
If yes, specify:

Has the participant had any alcohol or done any recreational drugs in...
the last 2 months? Yes No Specify:
the last 2 weeks? Yes No
the last 24 hours? Yes No



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Interview Information

Interview date (MM/DD/YYYY)	Start time (HH:MM)	End time (HH:MM)
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Has the participant experienced any of the following symptoms in the past 24 hours?

- Runny nose Yes No
- Cough/sore throat Yes No
- Fever/chills/night sweats Yes No
- Sinus infection Yes No
- Diarrhea/vomiting Yes No
- Rash Yes No
- Shortness of breath Yes No

Other illnesses, specify:

Study Completion

Did the participant complete the study? Yes No

Date of withdrawal:

MM/DD/YYYY

Reason for withdrawal:

- Withdrew informed consent
- Lost to follow-up
- Screen failure
- Sponsor decision
- Death
- Investigator decision
- Other, specify:



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Section I Demographic Information

1. Height in
 cm

2. Weight lb
 kg

3. Education - number of years completed since last study interview:

4. Current marital status*

5. Employment status - Select one

Employed outside home Student Unemployed not looking for work

Employed at home Worker's compensation Disabled, at age

Homemaker Unemployed looking for work Retired, not disabled, at age

6. Domestic status - Select all that apply

- | | | | |
|----------------------------|--|--------------------------------------|--|
| Living alone | <input type="checkbox"/> Yes <input type="checkbox"/> No | Living with other relative | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Living with spouse/partner | <input type="checkbox"/> Yes <input type="checkbox"/> No | Living with friend/companion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Living with sibling | <input type="checkbox"/> Yes <input type="checkbox"/> No | Living with domestic help | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Living with children | <input type="checkbox"/> Yes <input type="checkbox"/> No | Living with health related companion | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Living with parent | <input type="checkbox"/> Yes <input type="checkbox"/> No | Living in nursing or sheltered home | <input type="checkbox"/> Yes <input type="checkbox"/> No |



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Section II Family History

7. Please review the information previously provided for siblings and make any additions or corrections as needed. Provide information for the participant's full biological siblings only (do not include half/step-siblings).

(Does the participant have any siblings?) [] No [] Yes [] Don't know

Birth order	Year of birth	Gender	Alive	MS	Dominant hand*
First <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Second <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Third <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Fourth <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Fifth <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Sixth <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Seventh <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Eighth <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]
Ninth <input type="checkbox"/>	[]	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[]



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Section II Family History - Continued

8. Please review the information previously provided for half siblings and make any additions or corrections as needed.

(Does the participant have any half siblings?) No Yes Don't know

Year of birth	Gender	Alive	MS	Dominant hand*
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>

9. Please review the information provided at the first study visit regarding the participant's blood relatives who have been diagnosed with MS and provide corrections and updates as needed. Since the last study interview, has the participant learned of any blood relatives (not marriage) that have been diagnosed with MS? If yes, please describe the specific relationship to the participant.

(Does the participant have any additional blood relatives (not marriage) that have been diagnosed with MS?)

No Yes Don't know

Relationship		Describe
1. Father	<input type="checkbox"/>	
2. Mother	<input type="checkbox"/>	
3. Father's father	<input type="checkbox"/>	
4. Father's mother	<input type="checkbox"/>	
5. Mother's father	<input type="checkbox"/>	
6. Mother's mother	<input type="checkbox"/>	
7. Uncle(s) father's side	<input type="checkbox"/>	
8. Aunt(s) father's side	<input type="checkbox"/>	
9. Uncle(s) mother's side	<input type="checkbox"/>	
10. Aunt(s) mother's side	<input type="checkbox"/>	
11. 1st cousin(s) father's side	<input type="checkbox"/>	
12. 2nd cousin(s) father's side	<input type="checkbox"/>	
13. 1st cousin(s) mother's side	<input type="checkbox"/>	
14. 2nd cousin(s) mother's side	<input type="checkbox"/>	



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Section II Family History - Continued

10. Partner Information -

Please review the information previously provided for partners with whom the participant has had a child, and make any additions or corrections as needed. See below for ethnicity/race reference numbers.

(Does the participant have any children?) No Yes Don't know

Partner	Year of birth	Gender	Alive	MS	Dominant hand*
1.	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Ethnicity	<input type="text"/>	Mother's ethnicity	<input type="text"/>	Father's ethnicity	<input type="text"/>
Race	<input type="text"/>	Mother's race	<input type="text"/>	Father's race	<input type="text"/>
Number of children	<input type="text"/>	Birth state/Province	<input type="text"/>	Birth country	<input type="text"/>

Partner	Year of birth	Gender	Alive	MS	Dominant hand*
2.	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Ethnicity	<input type="text"/>	Mother's ethnicity	<input type="text"/>	Father's ethnicity	<input type="text"/>
Race	<input type="text"/>	Mother's race	<input type="text"/>	Father's race	<input type="text"/>
Number of children	<input type="text"/>	Birth state/Province	<input type="text"/>	Birth country	<input type="text"/>

Partner	Year of birth	Gender	Alive	MS	Dominant hand*
3.	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Ethnicity	<input type="text"/>	Mother's ethnicity	<input type="text"/>	Father's ethnicity	<input type="text"/>
Race	<input type="text"/>	Mother's race	<input type="text"/>	Father's race	<input type="text"/>
Number of children	<input type="text"/>	Birth state/Province	<input type="text"/>	Birth country	<input type="text"/>

- Ethnicity**
- Hispanic or Latino
 - Non Hispanic or Latino
 - Don't Know

- Race**
- | | |
|--|--|
| 1. American Indian or Alaska Native | 5. Black or African American |
| 2. Middle Eastern | 6. Native Hawaiian or other Pacific Islander |
| 3. South Asian (India, Nepal, Pakistan, Bhutan, Bangladesh, Maldives, Sri Lanka and Suvadives) | 7. White |
| 4. Other Asian | 8. Don't know |



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Section II Family History - Continued

11. Participant's offspring - Please review the information previously provided for the participant's offspring and make any additions or corrections as needed. Indicate the corresponding partner number from question 10 for each child in the box next to the birth order.

Birth order	Year of birth	Gender	Alive	MS	Dominant hand*
First Partner <input type="text"/>	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Second	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Third	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Fourth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Fifth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Sixth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Seventh	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Eighth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
Ninth	<input type="text"/>	<input type="checkbox"/> Male <input type="checkbox"/> Female	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>



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Section III Demyelinating Diseases - MS

N/A - Mark if this is a Control without a demyelinating disease and skip to Section IV - Medical history

12. Is the participant diagnosed with a clinically isolated syndrome or with Multiple Sclerosis?

No Yes -- Clinically isolated syndrome Yes -- Multiple Sclerosis

If the participant is currently diagnosed with MS, was he/she diagnosed with a clinically isolated syndrome at the last study interview?

No Yes Not Applicable

If yes, at what age was the participant diagnosed with Multiple Sclerosis by a neurologist or other physician?

Years old

12a. If the participant is diagnosed with MS, which of the following best characterizes the participant's disease?

Note: An exacerbation is defined as a development of new symptoms or a worsening of existing symptoms that lasts longer than 48 hours in the absence of a fever or infection.

<input type="checkbox"/>	<u>Relapsing remitting</u> - Participant has experienced two or more exacerbations of being worse for a period of time followed by an improvement in condition. In between exacerbations the participant is stable.
<input type="checkbox"/>	<u>Secondary progressive</u> - Participant's disease began with sporadic exacerbations separated by periods of stability and has changed to the point where symptoms have been getting progressively worse even when not having an exacerbation. Did this change take place after the last study interview? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, at what age did this change take place? <input type="text"/> Years old
<input type="checkbox"/>	<u>Primary progressive</u> - From onset, participant's disease has steadily progressed, even when not having an exacerbation.

12b. Is the participant currently experiencing an MS exacerbation?

No Yes Don't know



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Section III Demyelinating Diseases - MS (Continued)

12c. Has the participant experienced any exacerbations in the last 5 years?

No Yes Don't know Not Applicable

If yes, please list the details for the exacerbations in the table below. Only list exacerbations that the participant can recall with great accuracy.

Date of Onset (MM/DD/YYYY)	Source (Check all that apply)	Symptoms (Check all that apply)	Full Recovery
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know
	<input type="checkbox"/> Personal Recall <input type="checkbox"/> Medical Records	<input type="checkbox"/> Vision <input type="checkbox"/> Weakness <input type="checkbox"/> Balance <input type="checkbox"/> Other: <input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know



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Section III Demyelinating Diseases

12. Is the participant currently diagnosed with Neuromyelitis Optica?

- No Yes

12a. Have any attacks occurred since the last study interview?

- No Yes Don't know

If yes, please provide the following information for the most recent attacks:

12b. Date of most recent attack before this interview

Not Applicable

MM/DD/YYYY

12c. Were symptoms of this attack visual or spinal?

- Visual
 Spinal
 Both
 Don't know

12d. Date of next most recent attack before this interview

Not Applicable

MM/DD/YYYY

12e. Were symptoms of this attack visual or spinal?

- Visual
 Spinal
 Both
 Don't know



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Section III Demyelinating Diseases

12. Is the participant currently diagnosed with Optic Neuritis?

 No Yes

12a. Have there been any recurrences since the last study interview?

 No Yes Don't know

Date of recurrence	Eye*	Treatment of recurrence	
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="checkbox"/> None <input type="text"/>
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="checkbox"/> None <input type="text"/>
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="checkbox"/> None <input type="text"/>



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Section III Demyelinating Diseases

12. Is the participant currently diagnosed with Transverse Myelitis?

No Yes

12a. Have there been any attacks since the last study interview?

No Yes Don't know

Date of attacks	Treatment of attacks
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> None <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cytoxan <input type="text"/> <input type="checkbox"/> Don't know
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> None <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cytoxan <input type="text"/> <input type="checkbox"/> Don't know
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> None <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Other, specify: <input type="checkbox"/> Cytoxan <input type="text"/> <input type="checkbox"/> Don't know



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Section III Demyelinating Diseases

12. Is the participant currently diagnosed with Acute Disseminated Encephalomyelitis?

- No Yes

12a. Have there been any relapses since the last study interview?

- No Yes Don't know

If yes, please provide the following information for the two most recent relapses:

12b. Date of most recent relapse before this interview

MM/DD/YYYY

12c. Date of treatment for this relapse

MM/DD/YYYY

None

12d. Treatment

- Steroids
 Plasmapheresis
 Cytoxan
 Other, specify:
 Don't know

12e. Hospitalization for treatment

- No
 Yes, specify number of days: days
 Don't know

12f. Date of next most recent relapse before this interview

MM/DD/YYYY

12g. Date of treatment for this relapse

MM/DD/YYYY

None

12h. Treatment

- Steroids
 Plasmapheresis
 Cytoxan
 Other, specify:
 Don't know

12i. Hospitalization for treatment

- No
 Yes, specify number of days: days
 Don't know



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Section III Demyelinating Diseases - Original (V1)

N/A - Mark if this is a Control without a demyelinating disease and skip to Section IV - Medical history

12. Is the participant currently diagnosed with Multiple Sclerosis?

No Yes

12a. If yes, at what age was the participant diagnosed with Multiple Sclerosis by a neurologist or other physician?

Years old

12b. Which of the following best characterizes the participant's disease?

Note: An exacerbation is defined as a development of new symptoms or a worsening of existing symptoms that lasts longer than 48 hours in the absence of a fever or infection.

Clinically isolated syndrome (not Optic Neuritis or Transverse Myelitis) - Participant has experienced only one exacerbation.

Date of occurrence

MM/DD/YYYY

Relapsing remitting - Participant has experienced two or more exacerbations of being worse for a period of time followed by an improvement in condition. In between exacerbations the participant is stable.

Secondary progressive - Participant's disease began with sporadic exacerbations separated by periods of stability and has changed to the point where symptoms have been getting progressively worse even when not having an exacerbation.

At what age did this change take place? Years old

Primary progressive - From onset, participant's disease has steadily progressed, even when not having an exacerbation.

12c. Is the participant currently experiencing an exacerbation?

No Yes Don't know

12d. **If no**, how long has it been since the start of the participant's last exacerbation?

Months Years Don't know

12e. How many relapses did the participant experience within the first two years? Not applicable Don't know

12f. How many relapses has the participant experienced in the last year? Not applicable Don't know

12g. Age of first symptom or exacerbation (may have occurred before clinical diagnosis)? Years old

12h. Age of second symptom or exacerbation? Years old Not applicable



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Section III Demyelinating Diseases - Original (V1)

12h. Have there been multiple attacks?

No

Yes

Don't know

Date of subsequent attacks	Treatment of subsequent attacks	
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> None <input type="checkbox"/> Other, specify: <input type="text"/>
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> None <input type="checkbox"/> Other, specify: <input type="text"/>
<input type="text"/> MM/DD/YYYY	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> None <input type="checkbox"/> Other, specify: <input type="text"/>



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Section III Demyelinating Diseases - Original (V1)

12. Is the participant currently diagnosed with Neuromyelitis Optica?

- No
- Yes

12a. Date of NMO diagnosis
MM/DD/YYYY

12b. Date of first symptoms
MM/DD/YYYY

12c. Were first symptoms visual or spinal (walking, sensory changes, bowel/bladder)?

- Visual
- Spinal
- Both
- Don't know

12d. Date of treatment None
MM/DD/YYYY

12e. Treatment for first attack

- Steroids
- Plasmapheresis
- Other, specify:
- Don't know

12f. Date of second attack Not applicable
MM/DD/YYYY

12g. Were symptoms of second attack visual or spinal?

- Visual
- Spinal
- Both
- Don't know

12h. Date of last attack before this interview Listed above
MM/DD/YYYY

12i. Were symptoms of last attack visual or spinal?

- Visual
- Spinal
- Both
- Don't know

12j. Has the participant ever been on immunomodulatory drugs (Copaxone, IFNs, etc.)?

- No
- Yes, specify medication name(s):
- Don't know

Site

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Visit Date

Section III Demyelinating Diseases - Original (V1)

12. Is the participant currently diagnosed with Optic Neuritis?

- No Yes

12a. Date of diagnosis

MM/DD/YYYY

12b. Date of first attack

MM/DD/YYYY

12c. Date of first treatment

MM/DD/YYYY

None

12d. Treatments for first attack

- Steroids
 Plasmapheresis
 Cytoxan
 Other, specify:
 Don't know

12e. Which eye?

- Right Left Both Don't know

12f. Was pain present in the eye?

- No Yes Don't know

12g. Was color vision affected?

- No Yes Don't know

12h. Degree of recovery from first attack %

12i. Any recurrences? No

Yes

Date of recurrence	Eye*	Treatment of recurrence	
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="text"/> <input type="checkbox"/> None
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="text"/> <input type="checkbox"/> None
<input type="text"/> MM/DD/YYYY	<input type="text"/>	<input type="checkbox"/> Steroids <input type="checkbox"/> Plasmapheresis <input type="checkbox"/> Cytoxan <input type="checkbox"/> Don't know	<input type="checkbox"/> Other, specify below: <input type="text"/> <input type="checkbox"/> None

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Subject Barcode

Visit Date

Section III Demyelinating Diseases - Original (V1)

12. Is the participant currently diagnosed with Transverse Myelitis?

- No Yes

12a. Date of diagnosis

MM/DD/YYYY

12b. Date of symptom onset

MM/DD/YYYY

12c. Date of clinical nadir (when symptoms were at their worst)

MM/DD/YYYY

12d. Date of first treatment

MM/DD/YYYY

- None

12e. Treatments for first attack

- Steroids
 Plasmapheresis
 Cytoxan
 Other, specify:
 Don't know

12f. Prior illness (within 30 days of onset)

- No
 Yes, specify date of onset:
 Don't know

MM/DD/YYYY

If Yes, specify illness (check all that apply):

- Fever Chills Muscle aches Diarrhea
 Nausea Vomiting Coughing Stuffy nose

Other, specify:

Don't know

12g. Prior vaccination (within 30 days of symptoms onset)

- No
 Yes, specify date:
 Don't know

MM/DD/YYYY

If Yes, specify vaccine (check all that apply):

- Chickenpox (varicella) German measles (rubella) Measles (rubeola)
 Smallpox Mumps Hepatitis A
 Hepatitis B Polio (shot) Polio (oral vaccine)
 Rabies Travel Flu shot
 Strep Meningococcal Don't know



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Section III Demyelinating Diseases - Original (V1)

12. Is the participant currently diagnosed with Acute Disseminated Encephalomyelitis?

- No Yes

12a. Date of diagnosis
MM/DD/YYYY

12b. Date of first symptoms
MM/DD/YYYY

12c. Date of first treatment None
MM/DD/YYYY

12d. Treatment

- Steroids
 Plasmapheresis
 Cytoxan
 Other, specify:
 Don't know

12e. Hospitalization for treatment

- No
 Yes, specify number of days: days
 Don't know

12f. Prior illness (within 30 days of onset)

- No
 Yes, specify date of onset:
MM/DD/YYYY
 Don't know

If Yes, specify illness (check all that apply):

- Fever Chills Muscle aches Diarrhea
 Nausea Vomiting Coughing Stuffy nose

Other, specify:
 Don't know

12g. Prior vaccination (within 30 days of symptoms onset)

- No
 Yes, specify date:
MM/DD/YYYY
 Don't know

If Yes, specify vaccine (check all that apply):

- Chickenpox (varicella) German measles (rubella) Measles (rubeola)
 Smallpox Mumps Hepatitis A
 Hepatitis B Polio (shot) Polio (oral vaccine)
 Rabies Travel Flu shot
 Strep Meningococcal Don't know



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Section III Demyelinating Diseases

13. Please indicate which of the following symptoms the participant has experienced for 2 or more days **since the last study interview**. Specify whether the symptom was experienced **during** an exacerbation, **not during** an exacerbation, **currently**, or **not experienced** since the last study interview.

Demyelinating diseases	During exacerbation	Not during exacerbation	Currently	Not experienced
1. Weakness in arms/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Weakness in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Difficulty walking/dragging a foot	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Loss of coordination in arms/hands	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Loss of coordination in legs/feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Stiffness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Difficulty with balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Shaking or tremors	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Paralysis of half or whole face	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Facial twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Speech articulation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Difficulty with swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Blindness or blurry vision in one eye or both	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Disturbed vision e.g., double vision, objects moving, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Sensory symptoms; loss of feeling, painful feeling, unable to feel position of fingers/arms/legs, swollen feeling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Vertigo	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Sharp, painful feeling in face not due to trauma or injury (Trigeminal neuralgia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Electric shock-like feeling when bending neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Itching, not due to other causes e.g. psoriasis, insect bites, etc.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Burning sensation in feet	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. Cognitive difficulties e.g., memory problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Sexual dysfunction, not caused by medication	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Urinary problems e.g., unusual urgency or hesitancy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Trouble with bowel movements	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Changes in mood or depression considered out of the ordinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Total paralysis of legs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Total paralysis of arms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Need for mechanical ventilation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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Section IV Medical History - Continued

16. Please review the information previously provided for infectious diseases/disorders and make any additions or corrections as needed.

Disease/Disorder	Participant*	Age of onset (years)	Father	Mother	Sibling	Paternal relative	Maternal relative	Child/Grandchild	Don't know	None
1. Mononucleosis/Epstein Barr virus	<input type="text"/>		<input type="checkbox"/>							
2. Viral hepatitis (A, B, C)	<input type="text"/>		<input type="checkbox"/>							
3. Chickenpox	<input type="text"/>		<input type="checkbox"/>							
4. Shingles	<input type="text"/>		<input type="checkbox"/>							
5. German measles (rubella)	<input type="text"/>		<input type="checkbox"/>							
6. Measles (rubeola)	<input type="text"/>		<input type="checkbox"/>							
7. Strep throat	<input type="text"/>		<input type="checkbox"/>							
8. Mumps	<input type="text"/>		<input type="checkbox"/>							
9. Febrile seizures	<input type="text"/>		<input type="checkbox"/>							
10. Lyme disease	<input type="text"/>		<input type="checkbox"/>							
11. Polio	<input type="text"/>		<input type="checkbox"/>							
12. Tuberculosis	<input type="text"/>		<input type="checkbox"/>							
13. Cold sores	<input type="text"/>		<input type="checkbox"/>							
14. Syphilis	<input type="text"/>		<input type="checkbox"/>							
15. Gonorrhea	<input type="text"/>		<input type="checkbox"/>							
16. Genital herpes	<input type="text"/>		<input type="checkbox"/>							
17. Chlamydia	<input type="text"/>		<input type="checkbox"/>							
18. HIV/AIDS	<input type="text"/>		<input type="checkbox"/>							
19. Mycoplasma pneumonia	<input type="text"/>		<input type="checkbox"/>							
20. Other: <input type="text"/>	<input type="text"/>		<input type="checkbox"/>							
21. Other: <input type="text"/>	<input type="text"/>		<input type="checkbox"/>							
22. Other: <input type="text"/>	<input type="text"/>		<input type="checkbox"/>							

16a. Has the participant ever been hospitalized for an infection? No Yes Don't know

16b. If yes, provide details of hospitalization below. If hospitalized more than once, indicate first and last hospitalization.

i. Description of first infection

ii. Date of first hospitalization (MM/YYYY)

iii. Description of last infection

iv. Date of last hospitalization (MM/YYYY)



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Section IV Medical History - Continued

19. Has the participant received any of the following vaccinations since the last study interview? If so, indicate month and year of the most recent vaccination.

Disease

Month / Year

1. Chickenpox (varicella)

No Yes Don't know

2. German Measles (rubella)

No Yes Don't know

3. Measles (rubeola)

No Yes Don't know

4. Smallpox

No Yes Don't know

5. Mumps

No Yes Don't know

6. Hepatitis A

No Yes Don't know

7. Hepatitis B

No Yes Don't know

8. Polio (shot)

No Yes Don't know

9. Polio (oral vaccine)

No Yes Don't know

10. Rabies

No Yes Don't know

11. Travel
(e.g., yellow fever, cholera, etc.)

No Yes Don't know

Specify:

12. Flu shot

No Yes Don't know



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Section IV Medical History - Continued

19. Has the participant received any of the following vaccinations since the last study interview? If so, indicate month and year of the most recent vaccination.

Disease		Month / Year
13. Pneumococcal (strep)	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
14. Meningococcal	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
15. DTP/DTaP	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="text"/>
16. Other:	<input type="text"/>	<input type="text"/>
17. Other:	<input type="text"/>	<input type="text"/>
18. Other:	<input type="text"/>	<input type="text"/>

20. Has the participant ever been diagnosed with whiplash as a result of an automobile accident or other accident?

No Yes Don't know

If yes, please enter the date when the accident resulting in the whiplash occurred, starting with the most recent occurrence.

20a. Date of most recent occurrence (MM/YYYY):

20b. Date of next most recent occurrence (MM/YYYY):

20c. Date of third most recent occurrence (MM/YYYY):



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Section V Reproductive Health

- N/A - Mark if this is a male and skip to Section VI
- N/A - Mark if this is a pre-pubescent female and skip to Section VI

21. Is the participant currently pregnant?

- No Yes

21a. If yes, what is the duration of this current pregnancy in weeks?

weeks

22. Has the participant been pregnant since the last study interview?

- No Yes

Year ended	Duration	Outcome*	Breastfed (how long?)	
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month
<input type="text"/>	<input type="text"/> Months	<input type="text"/>	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="text"/> <input type="checkbox"/> months <input type="checkbox"/> <1 month



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Section V Reproductive Health - Continued

23. Have the participant's menstrual cycles begun since the last study interview? No Yes

If so, at what age? [] years old

24. Have the participant's natural menstrual cycles ceased permanently since the last study interview?

No Yes Don't know NA (menstrual cycles had ceased before the last study interview, skip to question 27.)

24a. If no or don't know, what was the date of the participant's last menstrual cycle?

[]

24b. If yes, at what age did the participant's natural menstrual cycles cease?

MM/DD/YYYY

[] years old

24c. If yes, for what reason did the participant's natural menstrual cycles cease?

Natural Surgical Radiation or chemotherapy

25. Has the participant had any of the following menstrual problems since the last study interview?

Problem	Had since the last study interview	Had in the past two months	Age (onset)
1. Irregular menstrual cycles	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[] years
2. Excessive pain during menses	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[] years
3. Excessive bleeding during menses	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[] years
4. Premenstrual syndrome	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	<input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't know	[] years

26. Has the participant had any other menstrual problems since the last study interview?

No

Yes, specify:

[]

Don't know

27. Has the participant had her uterus surgically removed since the last study interview?

No

Yes, at what age did the participant have her uterus removed? [] years old

28. Has the participant had either of her ovaries surgically removed since the last study interview?

No

Yes, how many ovaries did she have removed? [] At what age? [] years old



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Section VI - Environmental Exposures

29. Has the participant used tobacco more frequently than once per month since the last study visit?

No

Yes

Type of product*	Month / Year Used		# per day	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>	
Other:	<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>
Other:	<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>
Other:	<input type="text"/>	<input type="text"/>	to <input type="text"/>	<input type="text"/>



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Section VI - Environmental Exposures - Continued

30. Has the participant changed residences since the last study visit? If yes, please list all residences the participant has lived in since the last study visit, beginning with the residence at the time of the last interview.

No Yes Don't know

Residence	Month/Year lived
[] City	[] to [] Month/Year Month/Year
[] State/province	
[] Country	
Nearby substance emitting facilities (within 1 mile) <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify below <input type="checkbox"/> Don't know	Primary source of drinking water*
[]	a. []
	b. []

Residence	Month/Year lived
[] City	[] to [] Month/Year Month/Year
[] State/province	
[] Country	
Nearby substance emitting facilities (within 1 mile) <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify below <input type="checkbox"/> Don't know	Primary source of drinking water*
[]	a. []
	b. []

Residence	Month/Year lived
[] City	[] to [] Month/Year Month/Year
[] State/province	
[] Country	
Nearby substance emitting facilities (within 1 mile) <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify below <input type="checkbox"/> Don't know	Primary source of drinking water*
[]	a. []
	b. []

Residence	Month/Year lived
[] City	[] to [] Month/Year Month/Year
[] State/province	
[] Country	
Nearby substance emitting facilities (within 1 mile) <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify below <input type="checkbox"/> Don't know	Primary source of drinking water*
[]	a. []
	b. []

Residence	Month/Year lived
[] City	[] to [] Month/Year Month/Year
[] State/province	
[] Country	
Nearby substance emitting facilities (within 1 mile) <input type="checkbox"/> No <input type="checkbox"/> Yes - Specify below <input type="checkbox"/> Don't know	Primary source of drinking water*
[]	a. []
	b. []



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Section VI - Environmental Exposures - Continued

31. Has the participant changed jobs since the last study interview? If yes, please provide the following information for all of the types of jobs the participant has held since the last study interview, beginning with the participant's job at the time of the last interview. No Yes Don't know

Type of job*	<input type="text"/>		Other, specify:	<input type="text"/>
Type of business	Worked from (Month/Year to Month/Year)			
<input type="text"/>	<input type="text"/>	to <input type="text"/>		
Main activities/Duties	Work setting*		Hours per week	<input type="text"/> hours
<input type="text"/>	<input type="text"/>			

Type of job*	<input type="text"/>		Other, specify:	<input type="text"/>
Type of business	Worked from (Month/Year to Month/Year)			
<input type="text"/>	<input type="text"/>	to <input type="text"/>		
Main activities/Duties	Work setting*		Hours per week	<input type="text"/> hours
<input type="text"/>	<input type="text"/>			

Type of job*	<input type="text"/>		Other, specify:	<input type="text"/>
Type of business	Worked from (Month/Year to Month/Year)			
<input type="text"/>	<input type="text"/>	to <input type="text"/>		
Main activities/Duties	Work setting*		Hours per week	<input type="text"/> hours
<input type="text"/>	<input type="text"/>			

Type of job*	<input type="text"/>		Other, specify:	<input type="text"/>
Type of business	Worked from (Month/Year to Month/Year)			
<input type="text"/>	<input type="text"/>	to <input type="text"/>		
Main activities/Duties	Work setting*		Hours per week	<input type="text"/> hours
<input type="text"/>	<input type="text"/>			

Type of job*	<input type="text"/>		Other, specify:	<input type="text"/>
Type of business	Worked from (Month/Year to Month/Year)			
<input type="text"/>	<input type="text"/>	to <input type="text"/>		
Main activities/Duties	Work setting*		Hours per week	<input type="text"/> hours
<input type="text"/>	<input type="text"/>			



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Section VII - Medications and Nutritional Supplements

32. For Cases Only - Has the participant taken any MS disease modifying medications (Rebif, Copaxone, Betaseron, Avonex, Novantrone, Tysabri, etc.) since the last study interview? Include any medications that the participant was receiving at the time of the last study interview. [] No [] Yes [] Don't know

Table with 7 columns: Drug, Rte.*, Dose (include units), Freq., Start date (MM/YYYY), Stop date (MM/YYYY), Reason stopped*. Contains 6 empty rows for data entry.

33. For Cases only - Has the participant taken any relapse/attack medications (adrenocorticotrophic hormone, prednisone, intravenous methylprednisone, etc.) since the last study interview? Include any medications that the participant was receiving at the time of the last study interview. [] No [] Yes [] Don't know

Table with 7 columns: Drug, Rte.*, Dose (include units), Freq., Start date (MM/YYYY), Duration (Taper, [] Days, [] Months, [] Years), Reason stopped*. Contains 8 empty rows for data entry.



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Section VII - Medications and Nutritional Supplements - Continued

34. Is the participant currently taking or have they since the last study interview taken any other medications, doctor prescribed or over the counter, for longer than two months? Include any medications that the participant was receiving at the time of the last study interview. No Yes Don't know

Drug	Rte.*	Dose (include units)	Freq.	Start date (MM/YYYY)	Stop date (MM/YYYY)	Reason stopped*
<input type="text"/>						
<input type="text"/>						
<input type="text"/>						
<input type="text"/>						
<input type="text"/>						
<input type="text"/>						
<input type="text"/>						

35. Does the participant currently take a multivitamin (exclude individual vitamins)? No Yes Don't know

35a. If yes, how many does the participant take per week?*

35b. If yes, what specific brand does the participant usually use?

35c. If yes, when did the participant last take a multivitamin?

MM/DD/YYYY

36. Has the participant received plasmapheresis since the last study interview? No Yes Don't know

37. Has the participant received any experimental treatments since the last study interview? No Yes Don't know

37a. If yes, please describe:

38. Is the participant on a modified diet (Swank, vegan, vegetarian, kosher, etc.)? No Yes Don't know

39. Has the participant ever been diagnosed with anorexia? No Yes Don't know

39a. If yes, what was the date of the original diagnosis?

MM/YYYY

39b. Is the participant currently diagnosed with anorexia?

No Yes Don't know

40. Has the participant ever been diagnosed with bulimia? No Yes Don't know

40a. If yes, what was the date of the original diagnosis?

MM/YYYY

40b. Is the participant currently diagnosed with bulimia?

No Yes Don't know



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Section VII - Medications and Nutritional Supplements - Continued

41. Does the participant regularly take any of the following supplements (as distinct from multivitamin use)?

Supplement	Taken?*	Occasional or continuous use*	If continuous, how long?
1. Vitamin A	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
2. Beta carotene	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
3. Vitamin C	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
4. Vitamin B-6	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
5. Vitamin D	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
6. Vitamin E	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
7. Calcium (includes Tums, etc.)	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
8. Selenium	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
9. Niacin	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
10. Zinc	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
11. Metamucil/Citrucel (fiber)	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
12. Potassium	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
13. Chromium	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
14. Folic acid	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months
15. Iron	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="text"/> <input type="checkbox"/> Months



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Section VII - Medications and Nutritional Supplements - Continued

41. Does the participant regularly take any of the following supplements (as distinct from multivitamin use)?

Supplement	Taken ?*	Occasional or continuous use*	If continuous, how long?
16. Soy estrogen	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
17. Magnesium	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
18. Lecithin	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
19. B-complex	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
20. St. John's wort	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
21. Gingko biloba	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
22. Cod liver oil	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
23. Vitamin B-12	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
24. Co-enzyme Q10	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
25. DHEA	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
26. Fish oil	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
27. Garlic	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
28. Evening primrose oil	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
29. Echinacea	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months
30. Ginseng	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="checkbox"/> Days <input type="checkbox"/> Months



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The following section contains questions relating to stress, anxiety, and trauma. These questions may remind some of upsetting incidents. As with all questions contained in this document, there is no completion requirement: you may choose to answer all, some, or none of the questions.



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Section VIII Stress / Anxiety - Chronic Stressors

45a. Financial Stress

During the <u>past month</u> did you have enough money to afford:	Definitely Yes	Mainly Yes	Mainly No	Definitely No	Decline to answer
1. The quality of medical and dental care you (your family) should have?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
2. Furniture or household equipment that needs to be replaced?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
3. A large unexpected bill (over \$250) for auto repair, etc.?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
4. In general, how do your finances usually work out at the end of the month? Do you usually end up with:	<input type="checkbox"/> Not enough money to make ends meet <input type="checkbox"/> Just enough money to make ends meet <input type="checkbox"/> A little money left over <input type="checkbox"/> Plenty of money left over <input type="checkbox"/> Decline to Answer				

45b. Work Stress

Here are some questions about your current job. For each question, please indicate how often these things happened (if the question is not applicable due to the nature of your work situation, please check "N/A") during the past month.

How often:	Never	Seldom	Some-times	Fairly Often	Often	N/A	Decline to answer
1. Does your supervisor criticize you over minor things?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
2. Do you have conflicts with your co-workers?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
3. Do you have conflicts with your supervisor?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
4. Is there constant pressure to keep working?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
5. Does there seem to be a rush or urgency about everything at work?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7
6. Are there unpleasant physical conditions on your job, such as too much noise, dust, etc.?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7



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Section VIII Stress / Anxiety - Chronic Stressors - Continued

45c. Social and Family Stress

Here are some questions about your current relationship with your family and friends. For each question, please indicate how often these things happened with your family and/or friends during the past month.

How often:	Never	Seldom	Some-times	Fairly Often	Often	Decline to answer
1. Do your family members and/or friends disagree with you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
2. Are your family members and/or friends critical of you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
3. Do your family members and/or friends get on your nerves?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6
4. Do your family members and/or friends get angry with you?	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6



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Section VIII Stress / Anxiety - Depression

46. Over the last 2 weeks, how often have you been bothered by any of the following problems?

How often:	Not at all	Several days	More than half the days	Nearly every day	Decline to answer
1. Little interest or pleasure in doing things	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
2. Feeling down, depressed, or hopeless	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
4. Feeling tired or having little energy	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
5. Poor appetite or overeating	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
6. Feeling bad about yourself -- or that you are a failure or have let yourself or your family down	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
8. Moving or speaking so slowly that other people could have noticed? Or the opposite -- being so fidgety or restless that you have been moving around a lot more than usual	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4

10. If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all Somewhat difficult Very difficult Extremely difficult Decline to answer

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Section VIII Stress / Anxiety - Anxiety

47. Please read each item and check the box for the reply which comes closest to how you have been feeling DURING THE LAST WEEK. Don't take too long to think over your replies; your immediate reaction to each item will probably be more accurate than a long thought-out response.

1. I feel tense or "wound up."

- Not at all
- Time to time/occasionally
- A lot of the time
- Most of the time
- Decline to answer

5. Worrying thoughts go through my mind.

- Only occasionally
- From time to time but not too often
- A lot of the time
- A great deal of the time
- Decline to answer

2. I get a sort of frightened feeling as if something awful is about to happen.

- Not at all
- A little but it doesn't worry me
- Yes, but not too badly
- Very definitely and quite badly
- Decline to answer

6. I can sit at ease and feel relaxed.

- Not at all
- Not often
- Usually
- Definitely
- Decline to answer

3. I get a sort of frightened feeling like "butterflies" in the stomach.

- Not at all
- Occasionally
- Quite often
- Very often
- Decline to answer

7. I get sudden feelings of panic.

- Not at all
- Not very often
- Quite often
- Very often indeed
- Decline to answer

4. I feel restless as if I have to be on the move.

- Not at all
- Not very much
- Quite a lot
- Very much indeed
- Decline to answer



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Section VIII Stress / Anxiety - Trauma

The following questions relate to traumatic events you may have experienced. You are not required to answer these questions. You may choose to answer all, some, or none.

48a. Have you ever been physically attacked or mugged by someone you did not know where you believed you could be seriously harmed or killed?

- Yes
 - Suspect or possible
 - No
 - Don't know/Decline to answer
- [GO TO Q.49a]

48b. At that time or shortly after, did you experience feelings of intense helplessness, fear, or horror?
Please use this scale to rate your experience on a scale of 1 to 10

- The worst I ever experienced
- None
- 1 2 3 4 5 6 7 8 9 10

48c. Has it happened more than once? Single Recurrent

48d. If single: Age at the time of the event? Age

48e. If recurrent: Age at the time of first event? Age

Age at the time of last event? Age

49a. Have you ever been physically attacked (hit, slapped, choked, burned or beat up) by someone you know (for example a parent, husband/wife, family member) where you believed you could be seriously harmed or killed?

- Yes
 - Suspect or possible
 - No
 - Don't know/Decline to answer
- [GO TO Q.50a]

49b. At that time or shortly after, did you experience feelings of intense helplessness, fear, or horror?
Please use this scale to rate your experience on a scale of 1 to 10

- The worst I ever experienced
- None
- 1 2 3 4 5 6 7 8 9 10

49c. Has it happened more than once? Single Recurrent

49d. If single: Age at the time of the event? Age

49e. If recurrent: Age at the time of first event? Age

Age at the time of last event? Age



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Section VIII Stress / Anxiety - Trauma - Continued

50a. Have you ever been physically neglected (for example not fed, not properly clothed, or left to take care of yourself when you were too young or ill) where you believed you or someone else could die or be seriously harmed?

- Yes, Suspect or possible, No, Don't know/Decline to answer. Includes instruction: GO TO Q.51a

50b. At that time or shortly after, did you experience feelings of intense helplessness, fear, or horror? Please use this scale to rate your experience on a scale of 1 to 10

- Scale from 1 (None) to 10 (The worst I ever experienced)

50c. Has it happened more than once? Single, Recurrent

50d. If single: Age at the time of the event? Age []

50e. If recurrent: Age at the time of first event? Age []

Age at the time of last event? Age []

51a. Were you ever touched or made to touch someone else in a sexual way because they forced you in some way or threatened to harm you if you didn't?

- Yes, Suspect or possible, No, Don't know/Decline to answer. Includes instruction: GO TO Q.52a

51b. At that time or shortly after, did you experience feelings of intense helplessness, fear, or horror? Please use this scale to rate your experience on a scale of 1 to 10

- Scale from 1 (None) to 10 (The worst I ever experienced)

51c. Has it happened more than once? Single, Recurrent

51d. If single: Age at the time of the event? Age []

51e. If recurrent: Age at the time of first event? Age []

Age at the time of last event? Age []



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Section VIII Stress / Anxiety - Trauma - Continued

52a. Have you ever had sex (oral, anal, genital) when you didn't want to because someone forced you in some way or threatened to harm you if you didn't?

Yes Suspect or possible No Don't know/Decline to answer

└ GO TO Q.53 ┘

52b. At that time or shortly after, did you experience feelings of intense helplessness, fear, or horror?

Please use this scale to rate your experience on a scale of 1 to 10

None

1 2 3 4 5 6 7 8 9 10

The worst I
ever experienced

52c. Has it happened more than once?

Single Recurrent

52d. If single: Age at the time of the event?

Age

52e. If recurrent: Age at the time of first event?

Age

Age at the time of last event?

Age



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Section IX - Conclusion

53. Does the participant have any questions or comments regarding this questionnaire or this study?

No

Yes



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Diagnosis for Study Ascertainment

Name of enrolling physician

Date

MM/DD/YYYY

Has the participant's diagnosis changed since the last study interview? No Yes

If yes, provide an explanation:

Section I - Clinically observed signs: List the participant's signs of MS (CIS, TM, ADEM, NMO, or ON) as observed by a neurologist and check the appropriate column(s) to indicate when each was exhibited.

Observed Sign	Observed since the last study visit	Currently observed	Not observed since last study visit
1. Cognitive dysfunction (slow information processing speed, executive dysfunction, memory loss, MMSE < 26, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Babinski sign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Changes in mood/depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Sensory loss/impairment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Dysarthria	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Bulbar dysfunction (eg., dysphagia)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Scotoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Facial paresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Facial twitching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Tremor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Spasticity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Weakness in upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Clumsy or useless hand syndrome	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Appendicular ataxia in upper extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Weakness in lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Appendicular ataxia in lower extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. Gait disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Pathological brisk reflexes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. Sensory level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. Loss of color vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Diagnosis for Study Ascertainment

Section I (Cont.) - Clinically observed signs: List the participant's signs of MS (CIS, TM, ADEM, NMO, ON) as observed by a neurologist and check the appropriate column(s) to indicate when each was exhibited.

Observed Sign	Observed since the last study visit	Currently observed	Not observed since last study visit
21. Corrected visual acuity < 20/40	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Pale optic disc	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Internuclear ophthalmoplegia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Sustained nystagmus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Disconjugate gaze	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	
28. Other: <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	



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Section II - MRI: Please provide the following information and submit the report for the participant's most recent MRI performed after the last study interview.

Brain MRI, date performed

Spinal cord MRI, date performed

MM/DD/YYYY

Not done

MM/DD/YYYY

Not done

MM/DD/YYYY

MM/DD/YYYY

Table with 9 columns: N/A = Not assessed, T1, Enhancing, T2/PD/FLAIR, Total # of MS lesions, Locations, Consistent with demyelinating disease. Rows include Supratentorial, Infratentorial, Cervical, and Thoracolumbar.

Have any new lesions >= 3mm in diameter occurred in any MRIs performed after the last study interview?

No Yes Not applicable Don't know

If yes, were the new lesions enhancing or non-enhancing?

Enhancing Non-enhancing Both

Section III - Cerebrospinal fluid: Please provide the following information and submit the report for any cerebrospinal fluid draws performed since the participant's last study interview.

Date performed

MM/DD/YYYY

Not done

Oligoclonal banding: No Yes, number of bands Indeterminate Not assessed

IgG index: Elevated? No Yes, result Normal range Not assessed

White cell count: /mm3 Not assessed

Total protein: mg/l mg/dl Not assessed

VDRL: Reactive Non-reactive Not assessed

Table for Borrelia antibodies with columns for IgG and IgM, and rows for ELISA and Western Blot.

Myelin basic protein: Not elevated Elevated, result Normal range Not assessed



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Diagnosis for Study Ascertainment

Section III Cerebrospinal fluid (Cont.): Please provide the following information and submit the report for any cerebrospinal fluid draws performed since the participant's last study interview.

Date performed

[]

[] Not done

MM/DD/YYYY

Oligoclonal banding: [] No [] Yes, number of bands [] Indeterminate [] Not assessed

IgG index: Elevated? [] No [] Yes, result [] Normal range [] Not assessed

White cell count: [] /mm³ [] Not assessed

Total protein: [] mg/l [] Not assessed [] mg/dl

VDRL: [] Reactive [] Non-reactive [] Not assessed

Table with Borrelia antibodies, ELISA, Western Blot, IgG, and IgM results.

Myelin basic protein: [] Not elevated [] Elevated, result [] Normal range [] Not assessed (ng/ml)

Section III Cerebrospinal fluid (Cont.): Please provide the following information and submit the report for any cerebrospinal fluid draws performed since the participant's last study interview.

Date performed

[]

[] Not done

MM/DD/YYYY

Oligoclonal banding: [] No [] Yes, number of bands [] Indeterminate [] Not assessed

IgG index: Elevated? [] No [] Yes, result [] Normal range [] Not assessed

White cell count: [] /mm³ [] Not assessed

Total protein: [] mg/l [] Not assessed [] mg/dl

VDRL: [] Reactive [] Non-reactive [] Not assessed

Table with Borrelia antibodies, ELISA, Western Blot, IgG, and IgM results.

Myelin basic protein: [] Not elevated [] Elevated, result [] Normal range [] Not assessed (ng/ml)



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Diagnosis for Study Ascertainment

Section IV - Evoked potentials: Please provide the following information and report for the participant's most recent available evoked potentials exam if performed after the last study interview.

	Date performed	Not done	Right side*	Left side*
1. Visual	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
2. Brainstem auditory	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
3. Somatosensory				
3a. Upper limbs	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
3b. Lower limbs	<input type="text"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

Section V - CNS biopsy: Please provide the following information and report for the participant's most recent available CNS biopsy if performed after the last study interview.

Date performed Not done
MM/DD/YYYY

Result:

Negative Indeterminate MS

Other (specify):

Section VI - Standardized assessment scales : Please provide the following information for the participant's most recent standardized assessment scales if performed after the last study interview.

Most Recent:

		Date performed	
1. EDSS	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Not done
2. 25 ft. walk	<input type="text"/> sec.	<input type="text"/>	<input type="checkbox"/> Not done
3. 9 hole peg	<input type="text"/> sec.	<input type="text"/>	<input type="checkbox"/> Not done
4. Ambulation index	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Not done
5. MSFC	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Not done
6. PASAT	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Not done



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Section VII - Differential diagnosis: Please provide the following information and report for any of the following exams performed on the participant since the last study interview to rule out other conditions.

Condition (test)	Not Done	Result	
		POS.	NEG.
Neuroophthalmic (e.g. slit lamp exam)			
1. Uveitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Neuroretinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Other <input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>
Genetic (Mendelian)			
4. Metachromatic leukodystrophy (arylsulfatase A)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Adrenoleukodystrophy (serum very long chain fatty acids)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Krabbe's disease (WBC betagalactocerebrosidase)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. CADASIL (Notch 3 gene mutation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Other <input type="text"/>		<input type="checkbox"/>	<input type="checkbox"/>
Metabolic			
9. B-12 deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Folate deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Vitamin E deficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neoplastic granulomatous disease/sarcoidosis			
12. ACE	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Chest X-ray	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Diagnosis for Study Ascertainment

Section VII (cont.)- Differential diagnosis:

Condition (test)	Not done	Result	
		POS.	NEG.
Infectious			
14. VDRL, MHA-TP, or RPR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. Borrelia IgG	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Borrelia IgM	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. HTLV- I/II	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
19. HSV-1 antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. HSV-2 antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. CMV antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. Hepatitis A antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. Hepatitis B surface antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. Hepatitis B antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. Hepatitis C antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Hepatitis C surface antigen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypercoagulable/Inflammatory			
27. Sjogren's syndrome (SSA, SSB)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Lupus (DS DNA)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Protein S	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
30. Protein C	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
31. ANCA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
32. ESR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
33. Antiphospholipid antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
34. Anti-cardiolipin antibody	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
35. Lupus anticoagulant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
36. ANA	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
37. Rheumatoid factor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
38. C3	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
39. C4	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
40. General anti-ENA panel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
41. Leiden mutation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



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Diagnosis for Study Ascertainment

Section VII (cont.) - Differential diagnosis:

Condition (test)		Result
Hematologic		
	Not done	
42. White blood count ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
43. Red blood count ($\times 10^6/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
44. Platelets ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
45. Polys (absolute) ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
46. Monocytes (absolute) ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
47. EOS (absolute) ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
48. Basos (absolute) ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
49. Lymphs (absolute) ($\times 10^3/\text{mm}^3$)	<input type="checkbox"/>	<input type="text"/>
Pathological specimens		
50. Biopsy	<input type="checkbox"/>	
Tissue type <input type="text"/>	Result <input type="text"/>	
51. Biopsy	<input type="checkbox"/>	
Tissue type <input type="text"/>	Result <input type="text"/>	
52. Biopsy	<input type="checkbox"/>	
Tissue type <input type="text"/>	Result <input type="text"/>	
53. Biopsy	<input type="checkbox"/>	
Tissue type <input type="text"/>	Result <input type="text"/>	

Section VIII - ASIA impairment scale

Has the participant been diagnosed with TM or NMO?

- No
- Yes
- Don't know

If yes, what was the ASIA impairment scale score at the most recent exam since the participant's last study interview?

At most recent exam: A B C D E Not performed



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Section IX - NMO IgG

Has the participant ever been tested for NMO IgG?

 No Yes Don't know

If yes, record date performed

MM/DD/YYYY

Result:

 Positive Negative

Section X - Neuro-ophthalmologic Tests

Please provide the following information for the participant's most recent neuro-ophthalmologic assessments.

1. Optical coherence tomography (OCT):

Date performed

MM/DD/YYYY

 Not done

Retinal nerve fiber layer (RNFL):	Right eye (OD)	Left eye (OS)
Average	<input type="text"/> μm <input type="checkbox"/> Not assessed	<input type="text"/> μm <input type="checkbox"/> Not assessed
Temporal	<input type="text"/> μm <input type="checkbox"/> Not assessed	<input type="text"/> μm <input type="checkbox"/> Not assessed
Nasal	<input type="text"/> μm <input type="checkbox"/> Not assessed	<input type="text"/> μm <input type="checkbox"/> Not assessed
Superior	<input type="text"/> μm <input type="checkbox"/> Not assessed	<input type="text"/> μm <input type="checkbox"/> Not assessed
Inferior	<input type="text"/> μm <input type="checkbox"/> Not assessed	<input type="text"/> μm <input type="checkbox"/> Not assessed
Total macular volume	<input type="text"/> mm^3 <input type="checkbox"/> Not assessed	<input type="text"/> mm^3 <input type="checkbox"/> Not assessed

2. Low contrast letter acuity:

Date performed

MM/DD/YYYY

 Not done

Record the number of letters correctly identified at the given contrast levels.

	Right eye (OD)	Left eye (OS)	Both eyes
1.25%	<input type="text"/> <input type="checkbox"/> Not assessed	<input type="text"/> <input type="checkbox"/> Not assessed	<input type="text"/> <input type="checkbox"/> Not assessed
2.5%	<input type="text"/> <input type="checkbox"/> Not assessed	<input type="text"/> <input type="checkbox"/> Not assessed	<input type="text"/> <input type="checkbox"/> Not assessed