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# South West Impact of Multiple Sclerosis (SWIMS) Project

## CIS Baseline Record Form

Date  
completed:  
(please fill this in)

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SWIMS OFFICE USE ONLY

Project  
Number:

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Initials:

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**SECTION 1**

## SECTION 1

The following questions ask about your experience of having clinically isolated syndrome (CIS). CIS is an episode of inflammation of the brain or spinal cord, which may have given you temporary problems with your eyes, or with muscle strength, balance, or co-ordination, or with pain, numbness, or tingling in your limbs.

1a) Roughly when did your **first** symptom(s) of CIS appear? 
**Month**                      **Year**  
    

1b) Roughly when did you **first** visit your GP about CIS? 
**Month**                      **Year**  
    

2. The following is a list of symptoms which may be experienced during an episode of inflammation of the brain or spinal cord. Please indicate which symptom(s) you experienced.

Please also indicate whether you made a complete recovery (i.e. the symptom has disappeared completely), or whether you have made a partial recovery (i.e. the symptom has improved but is still present currently).

<b>Symptom</b>	<i>Tick as applicable</i>	<b>Recovery</b> (please circle your answer)
1. Blurred vision	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
2. Double vision	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
3. Painful vision	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
4. Colour desaturation (changes in colour vision)	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
5. Other visual disturbance	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
6. Numbness	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
7. Pins and needles / tingling	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
8. Tiredness / fatigue	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
9. Muscle weakness	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
10. Problems with balance	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
11. Problems with co-ordination	<input style="width: 30px; height: 20px; border: 1px solid black;" type="checkbox"/>	COMPLETE / PARTIAL
Other symptom(s):		
12. _____		COMPLETE / PARTIAL
13. _____		COMPLETE / PARTIAL

## SECTION 2

3. Have you had any of the following tests or investigations for CIS? Please tick all the boxes that apply.

If possible please fill in the date that the investigation was carried out.

**Name of investigation**

**Month**

**Year**

**Location**

*Tick as applicable*

BRAIN SCAN

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*If you know which type of brain scan this was, please indicate:*

*MRI scan*

*CT scan*

**Month**

**Year**

**Location**

LUMBAR PUNCTURE

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ELECTRICAL TESTS  
(e.g. Visual Evoked)

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## SECTION 2

### YOUR DETAILS

Title: Mr / Mrs / Miss / Ms / Other: \_\_\_\_\_

First name(s): \_\_\_\_\_

Surname: \_\_\_\_\_

Previous name(s) (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Postcode \_\_\_\_\_

Telephone Number: \_\_\_\_\_

Email address: \_\_\_\_\_

Date of birth: \_\_\_\_\_

Gender:

Female

Male

Please indicate how you would prefer to complete your questionnaires:

*Paper booklets sent by post*

OR

*Online booklets via the internet*

Details of your family doctor (GP):

Name: Dr \_\_\_\_\_

Surgery address: \_\_\_\_\_  
\_\_\_\_\_

NHS number: \_\_\_\_\_

*(if known)*

Details of your neurologist (if known):

Name: \_\_\_\_\_

Hospital: \_\_\_\_\_

**Thank you for completing this form.**

Please return this form to the SWIMS Project Coordinating Office  
in the FREEPOST envelope provided. You do not need to use a stamp.

SWIMS OFFICE USE ONLY

Project Number:

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W								

Initials:

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