

QUESTIONNAIRE FOR PATIENTS WITH MULTIPLE SCLEROSIS

This questionnaire was developed to compile information about all of the Multiple Sclerosis patients in our practice.

This Questionnaire is completely optional. All of your information will remain confidential. We may at some time, compile the statistics of everyone's information in future articles that could be published. In the event any of the data is used, your information will only be associated with a number, never your name or initials.

Name _____ Age _____

Date of Birth _____ Male _____ Female _____

Marital Status (Married, Single, Divorced) _____

Age when first diagnosed with MS _____

Date of first diagnosis _____

***Were you first diagnosed with Relapsing Remitting MS?** ___ Yes ___ No

Age when first symptoms of MS occurred _____ Dates _____

Comments _____

Do you know which category you would fit in now?

Relapsing Remitting _____

Secondary Progressive _____

Primary Progressive _____

Progressive Relapsing _____

Which Diagnostic Tools were used to diagnose you with MS?

MRI _____ Brain _____ Cervical Spine _____ Thoracic Spine _____

Spinal Tap _____ was this positive? _____

Visual Evoked Potentials _____ was this positive? _____

Where were you born? _____

Where did you live for the first 15 years of life?

Are you currently on any of the disease modifying drugs? (Copaxone, Rebif, Avonex, Betaseron) _____

*Which one _____

If not, have you ever been and which ones?

If you have used more than one treatment, which ones, and when did you use them?

If, you are not on any of these medicines. Why?

If you stopped treatment, why?

Have you ever been involved in any MS related research?_____

If so, please describe_____

When was your last exacerbation?

How many exacerbations have you had?

How often do they occur?

Which of the following **best** describes your level of physical activity?

*I can ambulate more than ¼ of a mile without any difficulty or any assistive devices_____

*I can ambulate more than ¼ of a mile with some level of assistance_____

What type of assistance_____

*I ambulate less than ¼ of a mile using a cane_____

*I ambulate less than ¼ of a mile using a walker_____

*I can only ambulate short distances with a cane_____

*I can only ambulate short distances with a walker_____

*I can not ambulate; I use a wheelchair for all mobility, Independently_____

*I require assistance with wheelchair mobility and transfers_____

*Other_____

Of the following MS symptoms, which have you experienced?

Fatigue_____

Depression_____

Numbness/ Tingling_____

Cognitive Problems_____

Pain_____

Balance Problems_____

Visual problems_____

Poor Coordination_____

Muscle Spasticity_____

Gait disturbance_____

Bladder Problems_____

Dizziness_____

Bowel Problems_____

Tremors_____

Sexual Dysfunction_____

Slurred Speech_____

Weakness_____

Sensitive to heat_____

Other_____

Do you have any other chronic conditions such as Arthritis, Lupus or Fibromyalgia?

Were these diagnosed before or after being diagnosed with MS?

Do you have any biological Relatives with the diagnosis of MS? How are they related to you?

We want to thank-you very much for taking the time to fill out this questionnaire. We really appreciate your time and effort. By signing this it only indicates that the information you have given is accurate by your account.

Print Name

Signature

Date