Coastal Neurological Medical Group

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Multipe Sclerosis / Neurodegenarative Questionnaire

Patient Name ____________________________________ **Date** __________________

Circle appropriate answer for the following symptoms:

Are you taking your medication regularly?	Yes	No
What medication are you taking for MS? ____________________		
Are you having intolerable injection site reactions?	Yes	No
Do you feel you have adequate injection training?	Yes	No
How many times a week do you inject your medication___________		
Have you progressed?	Yes	No
Have you relapsed?	Yes	No
Are you having fatigue?	Yes	No
Are you having bladder symptoms?	Yes	No
Nocturia (urination at night)	Yes	No
Frequency (urination often)	Yes	No
Incontinence (loss of control of urination)	Yes	No
with cough or sneeze	Yes	No
without warning	Yes	No
urge	Yes	No
Are you having bowel incontinence (loss of control of bowel)	Yes	No
Are you having constipation?	Yes	No
Are you having pain?	Yes	No
If yes, where __________________________________		
Are you having numbness?	Yes	No
If yes, where __________________________________		
Are you having leg cramps?	Yes	No
Are you having muscle tightening, spasms or spasticity?	Yes	No
Are you excessively tired during the day?	Yes	No
Do you nap?	Yes	No
If yes, how often ______________________________		
Do you snore?	Yes	No
Do you have memory loss?	Yes	No
Are you depressed?	Yes	No
Do you exercise?	Yes	No
If yes, how many times a day ____________________		
How long each time _________________________		
Does hot weather or heat make your symptoms worse?	Yes	No
With heat or exercise, do you loose your vision?	Yes	No
Do you have good support from your family?	Yes	No