



Multiple Sclerosis Questionnaire

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Today's Date:

Agent:

Full Name:

Male or Female?

Height and weight:

Date of Birth:

1. Please list date diagnosed and at what age:

2. How many episodes have you had since diagnosed?

3. When was the most recent episode (month and year)?

4. Please note current neurological status:

- Normal
- Minimal residual impairment
- Moderate residual impairment
- Severe residual impairment

5. What symptoms do you usually experience?

- Weakness Numbness Blurring, double vision
- Light-headedness Incontinence Other

How often do you experience these, and list details if selected Other:

6. Do you have any problems with extremities, kidneys, or bladder? Yes No
If yes, give details.

7. How are you being treated?

8. What medications do you take, reason, dosage and how often?

9. How often do you see your doctor and when was last visit?

10. When was your most recent MRI (month and year)? If you are able to get a copy of your MRI, please attach it with this questionnaire as it will help us get the most accurate information from our inquiry.

11. Have you been diagnosed with depression or take any depression medication?
___ Yes ___ No
If yes, list diagnosis month and year as well as name, frequency, amount of medication.

12. Has your weight remained stable or have you ___ lost or ___ gained weight in the past year? ___ Yes ___ No
If Yes, by how much?

13. Please indicate type of tobacco EVER used:

Type:	Amount per (circle frequency):	Date last used:	Still use?
___ Smokeless	___ daily/monthly/yearly	_____	___ Yes ___ No
___ Cigarettes	___ per day/month/year	_____	___ Yes ___ No
___ Cigar	___ per day/month/year	_____	___ Yes ___ No
___ Patch/Gum	___ per day/month/year	_____	___ Yes ___ No