Neurologic Status Update:
Drs. Heyman, Mitchell, Zaydan and Mr. Ryan Orie

Name: ____________________________
Visit Date: _________________________

What is your diagnosis? _______________________________________________________________

How do you feel you are doing? ☐ improved ☐ stable ☐ somewhat worse ☐ a lot worse

Please list your most important questions/issues for today’s appointment (maximum of 3):

1) ________________________________________________________________________________

2) ________________________________________________________________________________

3) ________________________________________________________________________________

1. Are you weak anywhere? ☐ yes ☐ no

   If yes, list location(s), circle the weakest area: _______________________________________

2. How often do you exercise? ☐ never ☐ 1/week or less ☐ 2-3/week ☐ more than 3/week

3. Do you have difficulty/changes with your voice? ☐ yes ☐ no

4. Do you have difficulty/changes with swallowing? ☐ yes ☐ no

5. Have you had pneumonia in the last year? ☐ no ☐ once ☐ twice or more

6. Do you have excessive fatigue? ☐ no ☐ mild ☐ moderate ☐ severe

7. Do you awaken refreshed from sleep? ☐ yes ☐ no

8. Do you have memory or cognitive difficulty? ☐ none ☐ mild ☐ moderate ☐ severe

9. Do you use an assistive device for mobility? ☐ yes ☐ no

   If yes, please indicate all of those that apply:
   ☐ cane ☐ standard walker ☐ rolling walker
   ☐ wheelchair ☐ scooter ☐ power wheelchair

10. Have you fallen in the last 12 months? ☐ No

    ☐ Once ☐ Less than 1 fall/month ☐ More than 1 fall/month ☐ More than 1 fall/week

11. Are you having trouble with your vision? ☐ no ☐ right eye ☐ left eye ☐ both eyes

12. Have you previously had visual loss? ☐ no ☐ right eye ☐ left eye ☐ both eyes
13. If you are experiencing trouble in **one or both eyes**, please indicate below what kind:
   - ☐ jumpy/jerky vision
   - ☐ double vision
   - ☐ blurred vision
   - ☐ loss of color vision
   - ☐ eye pain
   - ☐ enlarged blind spot

14. How is your urinary **bladder** working?
   - ☐ normally no problems
   - ☐ need to empty again soon after going
   - ☐ urgency/rushing
   - ☐ hesitancy/slowness to start
   - ☐ On a typical night, how often do you get up to urinate?
     - ☐ 0-1 times
     - ☐ 1-2 times
     - ☐ 2-3 times
     - ☐ more than 3 times
   - ☐ use of catheters (indicate type)
     - ☐ self intermittent (________ times a day)
     - ☐ foley (urethral)
     - ☐ suprapubic

15. Do you require pads, diapers, or other incontinence products?  ☐ Never  ☐ Some Days  ☐ Everyday

16. How many **bladder infections** have you had in the last year?  ☐ none  ☐ 1  ☐ 2  ☐ 3 or more

17. How are your **bowels** working?  ☐ no problems
   - ☐ diarrhea
   - ☐ constipation
   - ☐ staining/seepage
   - ☐ incontinence

18. How frequent do you usually have a **bowel movement**? (Choose one)
   - ☐ once daily
   - ☐ more than once daily
   - ☐ 3-5 times per week
   - ☐ less than once weekly

19. Do you currently have numbness anywhere?  ☐ yes  ☐ no
   - **If yes**, list location(s), circle the **numbest** location. ____________________________________________

20. Do you have any muscle stiffness, spasms, or contractions?  ☐ yes  ☐ no
   - **If yes**, list location(s), circle the **most problematic** location. ____________________________________________

21. Do you currently have any tremor or shaking?  ☐ yes  ☐ no
   - **If yes**, list location(s), circle the **most problematic** location. ____________________________________________

22. Do you currently have pain anywhere?  ☐ yes  ☐ no
   - **If yes**, list location(s), circle the location of **worst** pain. ____________________________________________
23. Does heat/humidity make your symptoms worse?  □ yes  □ no
24. Do you have a problem with mood (apathy, irritability, sadness, or anxiety)?  □ yes  □ no
25. Have you had any thoughts of hurting or killing yourself or others?  □ yes  □ no

26. Over the past two weeks, how often have you been bothered by any of the following problems?
   1. Little interest or pleasure in doing things:
      □ not at all  □ several days  □ more than ½ the days  □ nearly every day
   2. Feeling down, depressed or hopeless:
      □ not at all  □ several days  □ more than ½ the days  □ nearly every day
27. Has your stress level changed in the past 6 months – 1 yr (at home, work, etc.)?  □ yes  □ no
   If yes, please explain: __________________________________________________________
28. Do you have enough support at home?  □ yes  □ no
   Please explain: _________________________________________________________________
29. Are you a member of the National MS society?  □ yes  □ no
30. Would you like information from the National MS society today?  □ yes  □ no
31. Do you work?  □ yes (_______hours/wk) Occupation: ____________________________  □ no  □ on disability
32. How many hours per week do you volunteer?  (_______hours/wk)
33. Is your weight □ stable □ gained □ lost _____ pounds, over the past _______ months
34. Have you had any blackouts or fainting?  □ yes  □ no
35. Have you had any seizures?  □ yes  □ no
36. Have you noticed any blood in your urine?  □ yes  □ no
37. Have you noticed any blood in your stool/bowel movements?  □ yes  □ no
38. Do you have any open wounds or sores on your skin? Location: _____________________ □ yes  □ no
39. Have you had any increase of your blood sugar? □ I don’t know □ yes  □ no
40. Do you have dry eyes?  □ yes  □ no
41. Have you been having chest pains?  □ yes  □ no
42. Have you been having irregular heart rate or rhythm?  □ yes  □ no
43. Have you had any dental or dry mouth problems?  □ yes  □ no
44. Do you have any red swollen joints?  □ yes  □ no
45. Have you had any hallucinations?  □ yes  □ no
46. Do you have breathing problems?  □ no  □ only with activity  □ even while at rest
IF YOU DO NOT HAVE MULTIPLE SCLEROSIS, PLEASE STOP FORM COMPLETION AT THIS POINT.

Multiple Sclerosis Patient Questionnaire

Please read the choices listed below and choose the one that best describes your own situation. This scale focuses mainly on how well you walk. You might not find a description that reflects your condition exactly, but please mark the ONE category that describes your situation the closest.

☐ 0  I may have some mild symptoms, mostly sensory due to MS but they do not limit my activity. If I do have an attack, I return to normal when the attack has passed.

☐ 1  I have some noticeable symptoms from my MS but they are minor and have only a small effect on my lifestyle.

☐ 2  I don’t have any limitations in my walking ability. However, I do have significant problems due to MS that limit daily activities in other ways.

☐ 3  MS does interfere with my activities, especially my walking. I can work a full day, but athletic or physically demanding activities are more difficult than they used to be. I usually don’t need a cane or other assistance to walk, but I might need some assistance during an attack.

☐ 4  I use a cane or a single crutch or some other form of support (such as touching a wall or leaning on someone’s arm) for walking all the time or part of the time, especially when walking outside. I think I can walk 25 feet in 20 seconds without a cane or crutch. I always need some assistance (cane or crutch) if I want to walk as far as 3 blocks.

☐ 5  To be able to walk 25 feet, I have to have a cane, crutch or someone to hold onto. I can get around the house or other buildings by holding onto furniture or touching the walls for support. I may use a scooter or wheelchair if I want to go greater distances.

☐ 6  To be able to walk as far as 25 feet I must have 2 canes or crutches or a walker. I may use a scooter or wheelchair for longer distances.

☐ 7  My main form of mobility is a wheelchair. I may be able to stand and/or take one or two steps, but I can’t walk 25 feet, even with crutches or a walker.

☐ 8  Unable to sit in a wheelchair for more than one hour.
MOBILITY

On the next two pages are categories of mobility limitations. Each category has some examples included to help you decide. All of the examples within a category may not apply to you. Please read all of the categories and check the SINGLE category that best describes your average condition in the past month. Compare your current condition to your mobility before you developed MS.

☐ 0 Although I have MS and some symptoms, my walking or running is not limited.

☐ 1 I am making minor adjustments in my work or lifestyle because of some difficulty in walking.
   I have given up some particularly strenuous activities because of walking problems.

☐ 2 I have to park closer to my destination because of difficulty in walking.
   I have given up some activities, such as long shopping trips, dancing, hiking, or other activities that require a lot of walking.

☐ 3 I find myself using the wall, other people’s arms, or furniture, to help support my walking at times, but I can walk at least 25 feet (i.e., 2 car lengths) without any support.
   I do not use a cane or similar support around the house, but do use it when I leave the house. I use a cane or similar support to avoid looking like I am drunk.
   I carry a cane even if I do not use it, because it makes me feel more secure.

☐ 4 I need a cane or similar support to get around in the house, as well as outside. I need to use a wall, furniture or other people’s arms to allow me to walk short distances (i.e., less than 25 feet).
   I do not walk anywhere without using some support on one side (e.g., wall, furniture, pushing shopping cart, cane, someone’s arm).

☐ 5 I need to hold onto something with both hands in order to walk 25 feet or more.
   I have to use two crutches, walker or pushcart in order to walk most of the time.

☐ 6 Even though I can take a step or two on my own, I need to use a wheelchair for any distances greater than 25 feet (i.e., 2 car lengths), or I am bedridden/essentially confined to a wheelchair.
HAND FUNCTION

Please read all of the categories and check the SINGLE category which best describes your worst hand function condition in the past month. Compare your current condition to your hand function before you developed MS.

☐ 0 Although I have MS and some symptoms, my hands have not been affected.

☐ 1 I have some problems with my hands, but it has not changed my activities.
   I do not write as well as I used to.

☐ 2 I am making a few adjustments in my activities because of some difficulty with coordination, shaking, and strength in my hands.
   I have reduced some activities requiring fine hand control, such as writing, handicrafts, typing, etc.

☐ 3 I am making many adjustments in my activities due to hand problems.

☐ 4 I have given up important activities due to hand problems.
   I am still able to do my activities, but they take me much longer.

☐ 5 Every day, difficulty with my hands prevents me from doing many of my activities.

VISION

Please read all of the categories and check the SINGLE category which best describes your overall visual condition (with glasses if you use them) over the past month. Compare your current condition to your vision before you developed MS.

☐ 0 MS has not affected my vision.
   I wear glasses but otherwise my vision is normal.

☐ 1 My vision is normal, but it has been affected in the past by MS.

☐ 2 I have visual symptoms of either blurred or double vision, but I am still able to do all of my usual activities.

☐ 3 Because of my visual problems, I have been forced to give up some of my usual activities, but after a period of rest I can usually return to these activities.

☐ 4 I am no longer able to maintain my original lifestyle because of my vision, and rest does not seem to help my vision.
   I can no longer drive a car because of my vision.

☐ 5 I cannot read, even with aids, or I am essentially blind.
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FATIGUE
Please read all of the categories and check the SINGLE category that best describes your fatigue condition in the past month. Compare your current condition to your fatigue level before you developed MS.

☐ 0 I do not notice being fatigued.
☐ 1 I experience fatigue for no apparent reason, but it has not changed my activities.
☐ 2 Fatigue occasionally forces me to change some of my activities (e.g., once a week or less).
☐ 3 Fatigue frequently forces me to change some of my activities (e.g., several times a week).
☐ 4 Every day, fatigue forces me to modify my daily activities, or I am always tired.
☐ 5 Every day, fatigue prevents me from doing many of my daily activities.

COGNITIVE SYMPTOMS
Problems with remembering, thinking, difficulties with calculations, confusion, difficulty remembering what you read, word recall, etc., compared to before you developed MS.
Please read all of the categories and check the SINGLE category which best describes your cognitive symptoms in the past month. Compare your current condition to your level of cognition before you developed MS.

☐ 0 I have not noticed any problems with memory or confusion.
☐ 1 I notice some problems with memory or confusion, but they do not interfere with my activities.
☐ 2 Memory problems or confusion occasionally affect some of my activities (e.g., once a week or less).
☐ 3 Memory problems or confusion frequently affect some of my activities (e.g., several times a week).
☐ 4 I constantly need to allow for problems with memory or confusion in my daily activities.
☐ 5 Every day, memory problems or confusion prevent me from doing many of my daily activities.
BLADDER/BOWEL

Please read all of the categories and check the SINGLE category which best describes your bladder or bowel symptoms in the past month even if you use a catheter or have had surgical procedures. Compare your current condition to your bladder/bowel function before you developed MS.

☐ 0  I have not noticed any problems with my bladder or bowel control.

☐ 1  I have some problems with bladder or bowel control (e.g., urinary frequency, urgency or hesitancy), but it does not interfere with my activities.
   I am aware of needing to control my bladder and bowel, and I do not have any problem with wetting or soiling.

☐ 2  Bladder or bowel control problems occasionally affect some of my activities (e.g., once a week or less.)
   I have trouble controlling my bladder or bowel once a week or less (e.g., dribbling).

☐ 3  Bladder or bowel control problems frequently affect some of my activities (e.g., several times a week).
   I have trouble controlling my bladder or bowel several times a week (e.g., wet or soil).

☐ 4  Every day, bladder or bowel control problems force me to modify my daily activities.

☐ 5  Every day, bladder or bowel control problems prevent me from doing many of my daily activities.

SENSORY SYMPTOMS

Problems with numbness, tingling, odd sensations, electric shock, burning, band-like sensation around trunk or extremities. Do not include aching pain or headaches.

Please read all of the categories and check the SINGLE category that best describes your sensory symptoms in the past month. Compare your current condition to your level of sensory function before you developed MS.

☐ 0  I have not noticed any problems with numbness or tingling.

☐ 1  I have some problems with numbness or tingling, but it does not interfere with my activities.

☐ 2  Numbness or tingling occasionally forces me to change some of my activities (e.g., once a week or less).

☐ 3  Numbness or tingling frequently affects some of my activities (e.g., several times a week).

☐ 4  Every day, numbness or tingling problems force me to modify my daily activities.

☐ 5  Every day, numbness or tingling prevents me from doing many of my daily activities.
SPASTICITY SYMPTOMS

Unusual tightening of muscles that feels like leg stiffness, jumping of legs, a repetitive bouncing of the foot, muscle cramping in legs or arms or leg going out tight and straight or drawing up.

Please read all of the categories and check the SINGLE category that most accurately describes your spasticity symptoms in the past month. Compare your current condition to your level of spasticity before you developed MS.

☐ 0 I have not noticed any problems with spasticity.
☐ 1 I notice some problems with spasticity, but they do not interfere with my activities.
☐ 2 Spasticity occasionally forces me to change some of my activities (e.g., once a week or less).
☐ 3 Spasticity frequently affects some of my activities (e.g., several times a week).
☐ 4 Every day, spasticity problems force me to modify my daily activities.
☐ 5 Every day, spasticity problems prevent me from doing many of my daily activities.

PAIN

Please read all of the categories and check the SINGLE category that most accurately describes your pain (regardless of cause) in the past month. Compare your current condition to your experience before you developed MS.

☐ 0 I have not noticed any problems with pain.
☐ 1 I notice some problems with pain, but they do not interfere with my activities.
☐ 2 Pain occasionally forces me to change some of my activities (e.g., once a week or less).
☐ 3 Pain frequently affects some of my activities (e.g., several times a week).
☐ 4 Every day, pain problems force me to modify my daily activities.
☐ 5 Every day, pain problems prevent me from doing many of my daily activities.
DEPRESSION

Please read all of the categories and check the SINGLE category that most accurately describes symptoms of depression in the past month. Compare your current condition to what you felt before you developed MS.

☐ 0  I have not noticed any problems with depression.
☐ 1  I notice some problems with depression, but they do not interfere with my activities.
☐ 2  Depression occasionally forces me to change some of my activities (e.g., once a week or less).
☐ 3  Depression frequently affects some of my activities (e.g., several times a week).
☐ 4  Every day, depression problems force me to modify my daily activities.
☐ 5  Every day, depression problems prevent me from doing many of my daily activities.

TREMOR/LOSS OF COORDINATION

Tremor is the rhythmic shaking of the head, hands or legs. Loss of coordination is clumsiness or imbalance (e.g., staggering gait or unsteady gait like being drunk).

Please read all of the categories and check the SINGLE category that most accurately describes your tremor and loss of coordination symptoms in the past month. Compare your current condition to your experience before you developed MS.

☐ 0  I do not have any tremor or loss of coordination.
□ 0   I have not noticed any problems with tremor or loss of coordination.
☐ 1  Sometimes I have some tremor or loss of coordination, but it does not interfere with my activities.
☐ 2  Tremor or loss of coordination occasionally forces me to change some of my activities (e.g., once a week or less).
☐ 3  Tremor or loss of coordination frequently affects some of my activities (e.g., several times a week).
☐ 4  Every day, tremor or loss of coordination problems forces me to modify my daily activities.
☐ 5  Every day, tremor or loss of coordination problems prevents me from doing many of my daily activities.

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