MS Relapse Evaluation—New Relapse

Patient's age in years: _____

Patient's sex (circle one): Male Female

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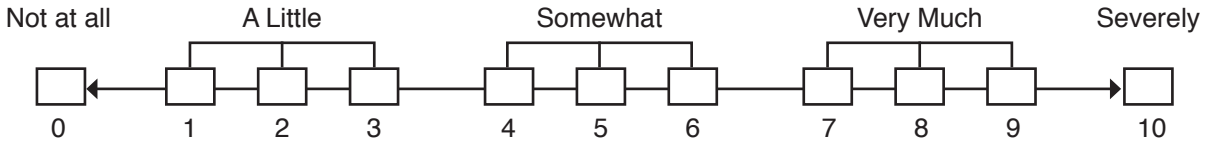
1) What are the new or worsening symptoms that you are currently experiencing? *(Check all that apply)*

- ☐ Vision changes
- ☐ Chewing/swallowing
- ☐ Hand/arm weakness
- ☐ Bowel problems
- ☐ Fatigue
- ☐ Difficulty walking
- ☐ Other: _____
- ☐ Speech changes
- ☐ Numbness/tingling
- ☐ Leg/foot weakness
- ☐ Sexual problems
- ☐ Muscle tightness or stiffness
- ☐ Coordination (tripping, dropping things)
- ☐ Dizziness/poor balance
- ☐ Pain, burning, itching
- ☐ Bladder problems
- ☐ Memory problems
- ☐ Thinking problems

2) When did these symptoms begin? *(Check one)*

☐ Within the last 3 days ☐ 4 -7 days ago ☐ 8 -15 days ago ☐ 16+ days ago

3) How much have these symptoms affected your daily activities or overall function? *(Mark one)*

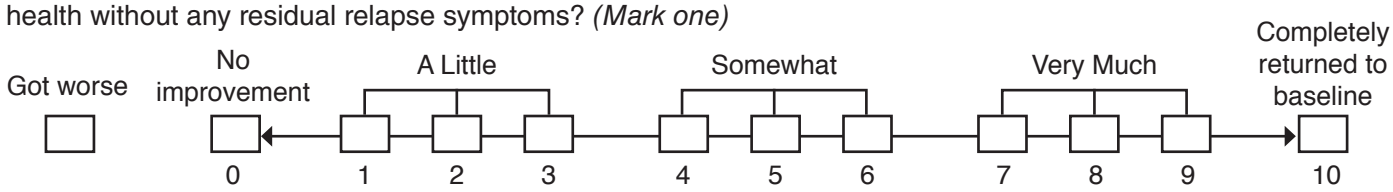


4) How many days/months ago was your last relapse (attack, exacerbation) prior to this current episode? _____

5) What treatment did you receive for your last relapse (attack, exacerbation)? *(Check all that apply)*

- ☐ IV steroid infusion
- ☐ Acthar/ACTH injections
- ☐ Other:
- ☐ Oral steroid tablets (only)
- ☐ No treatment *(skip questions 6 and 7)*
- ☐ Oral steroid tablets (after IV steroids)
- ☐ Not sure

6) After treatment for your last relapse (attack, exacerbation), how much did you return to your baseline state of health without any residual relapse symptoms? *(Mark one)*



7) Have you had any side effects from treatments for previous MS relapses (attacks, exacerbations)? *(Check all that apply)*

- ☐ Mood changes/depression/anxiety
- ☐ Sleep disturbance
- ☐ Stomach upset or heartburn
- ☐ High blood sugar
- ☐ Increased appetite
- ☐ Chills
- ☐ Weight gain
- ☐ Increased blood pressure
- ☐ Headache
- ☐ Increased fatigue
- ☐ Fever
- ☐ Infection
- ☐ Nausea and/or vomiting
- ☐ Low blood pressure
- ☐ Faintness (light headedness)
- ☐ Dizziness
- ☐ Muscle cramps
- ☐ Other:

If you have any questions, please ask your Nurse

For office use only

Date: _____ Patient initials: _____ _____ _____

Type of MS (circle one): RRMS PPMS SPMS

Type of visit (circle one): Phone Office

Questionnaire completed by (circle one): Patient Office Staff