

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

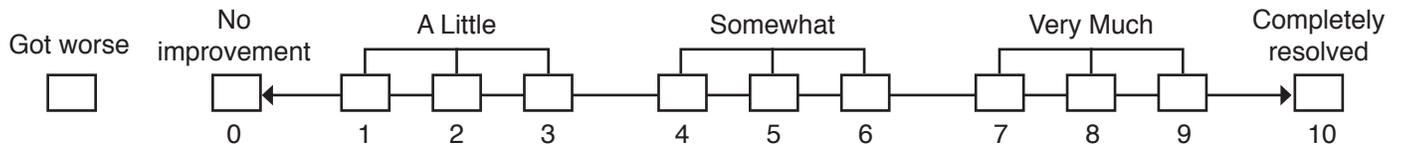
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

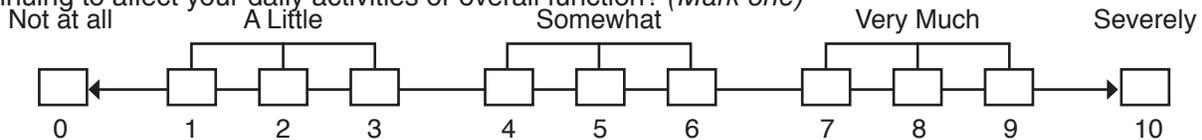
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

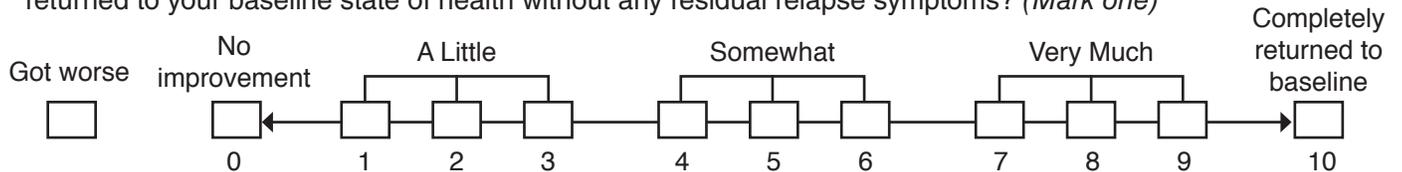
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6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
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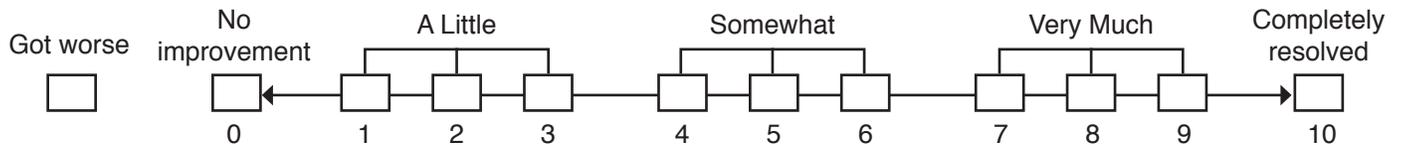
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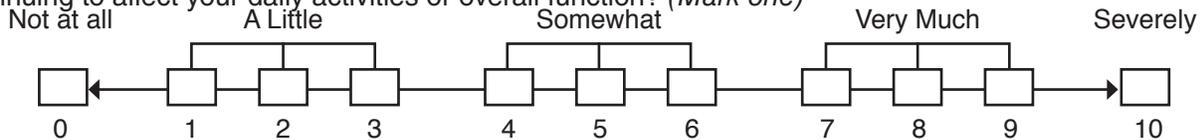
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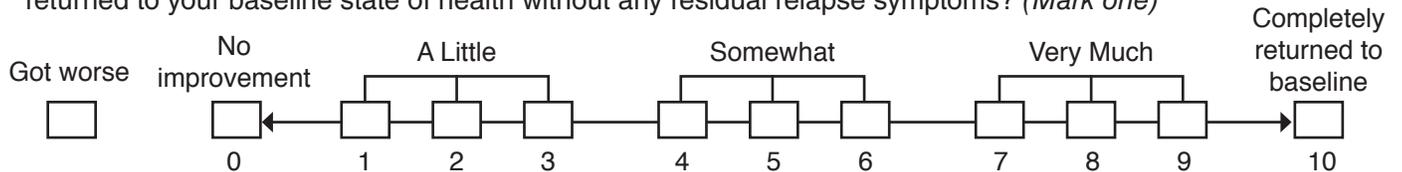
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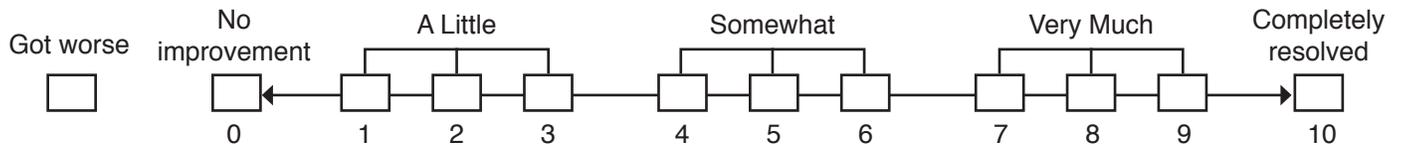
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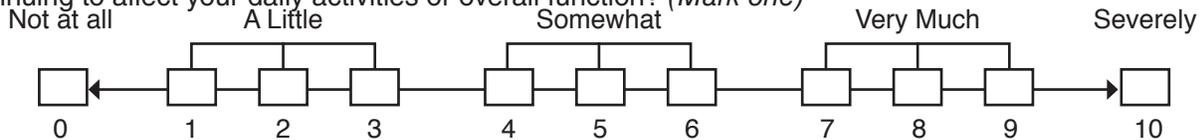
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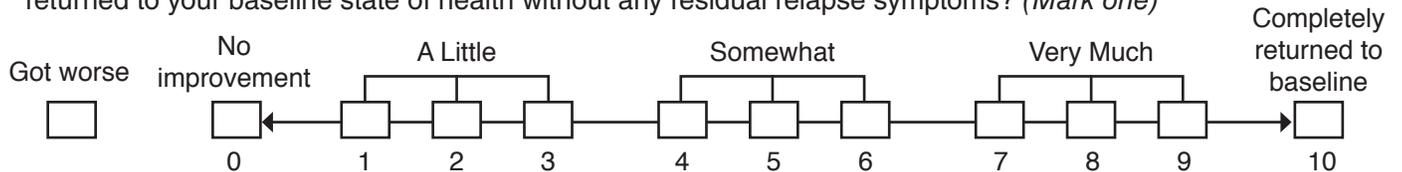
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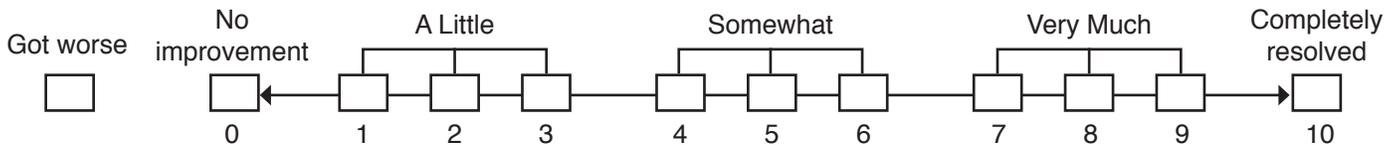
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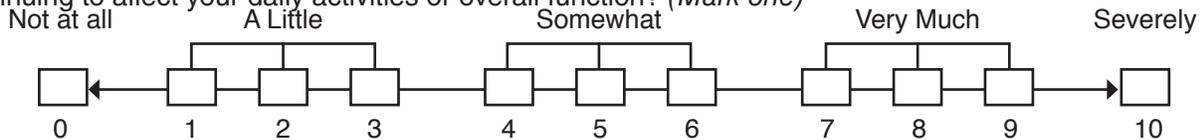
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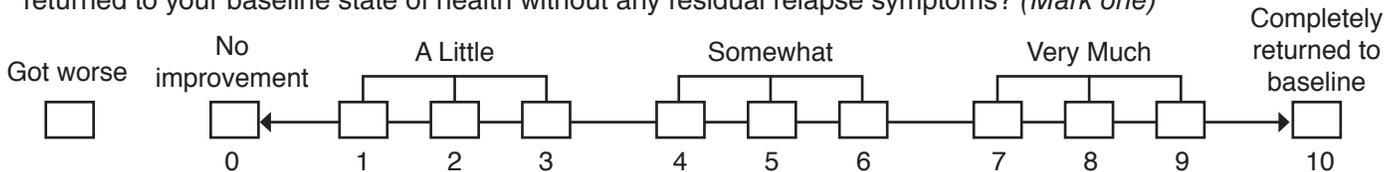
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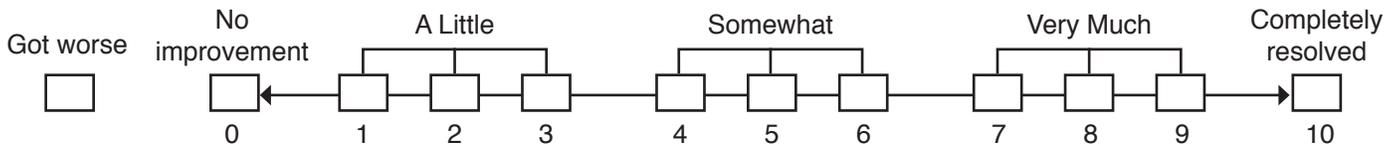
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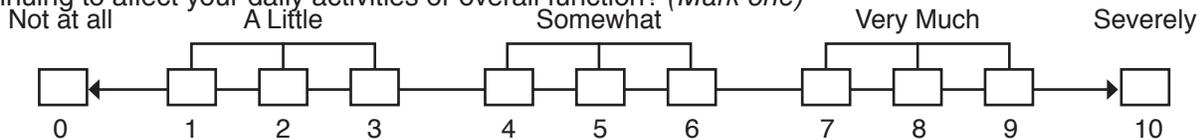
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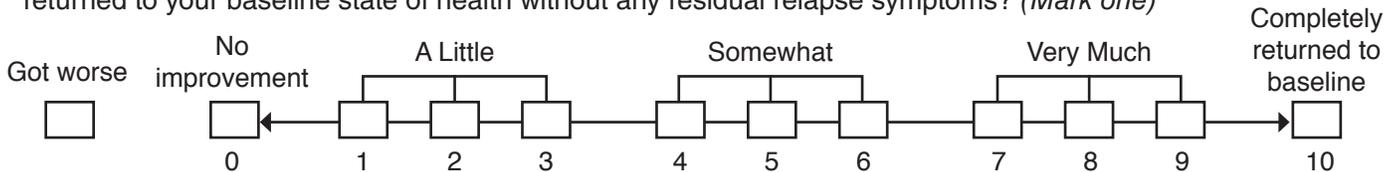
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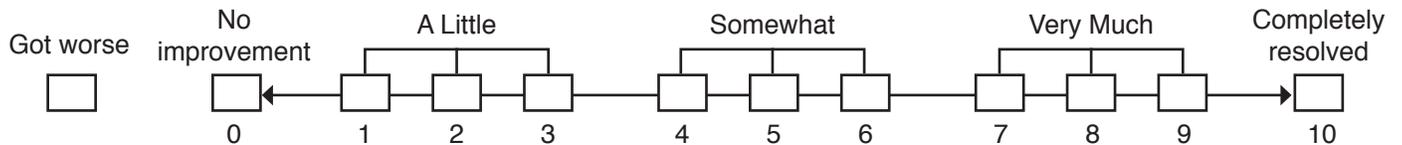
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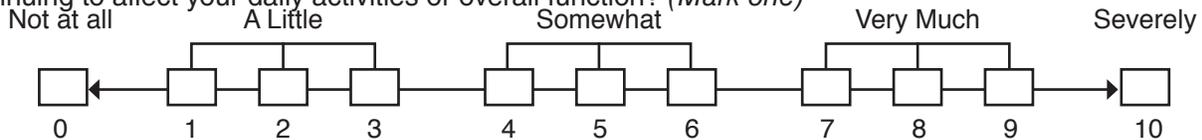
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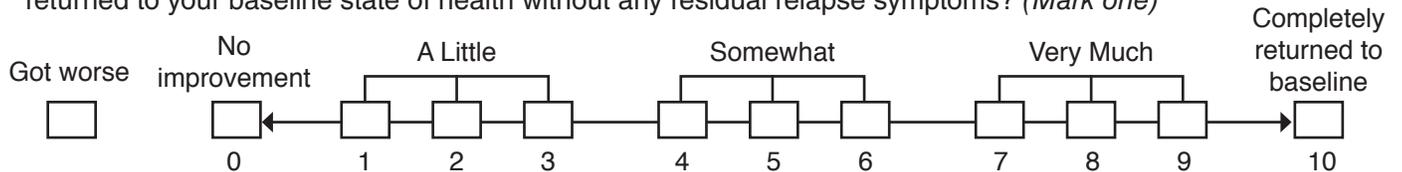
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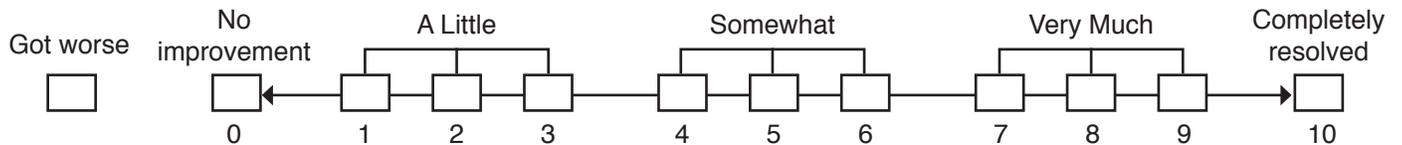
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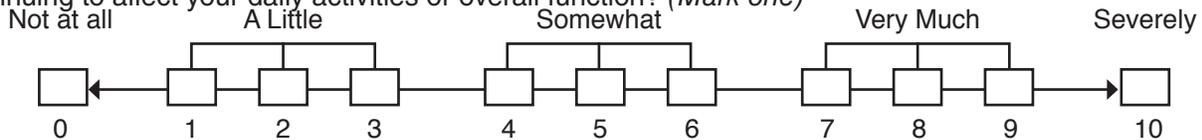
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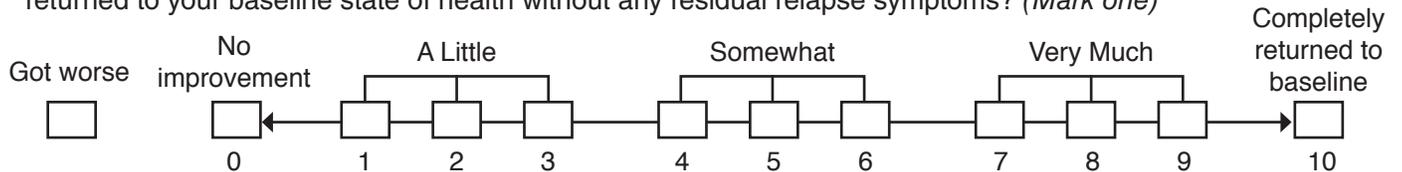
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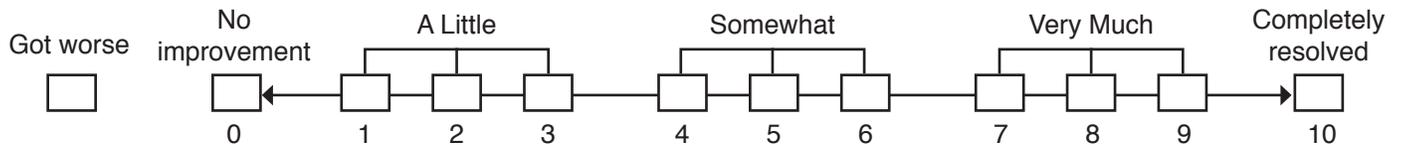
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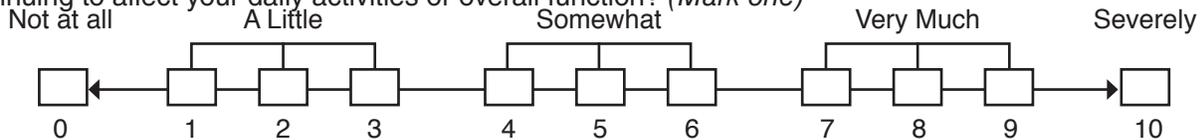
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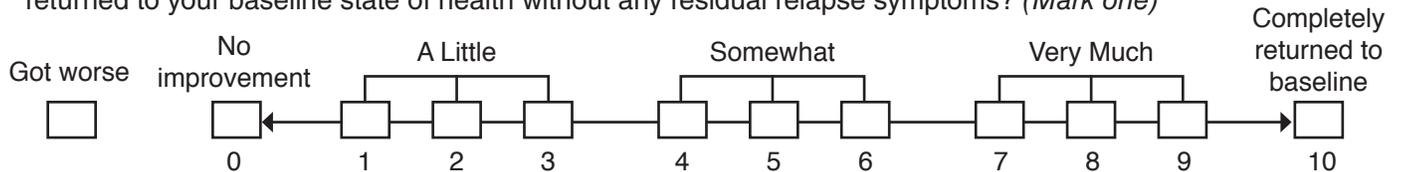
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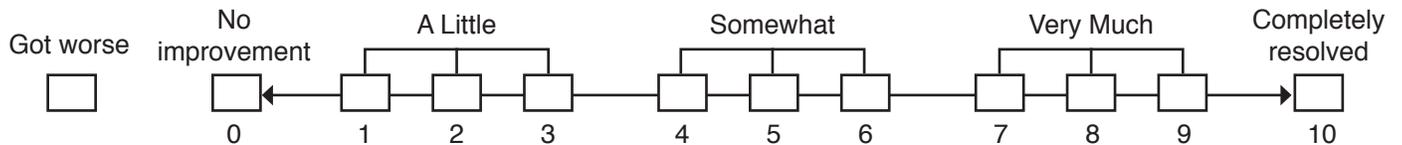
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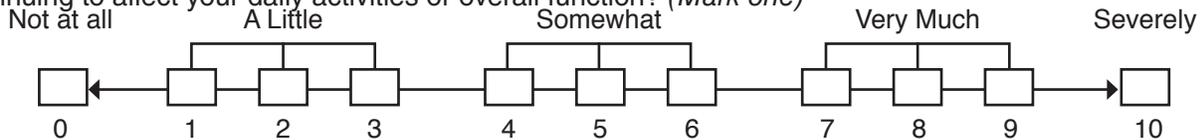
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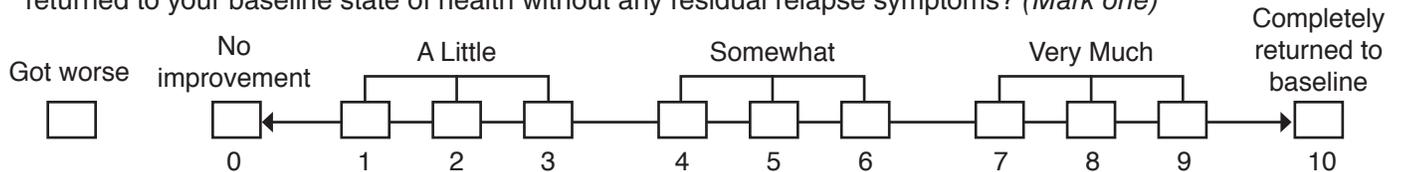
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| <input type="checkbox"/> Chills | <input type="checkbox"/> Infection | <input type="checkbox"/> Other: _____ |

If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

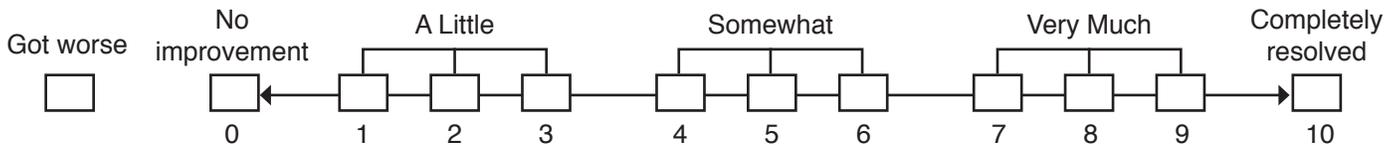
- | | | |
|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

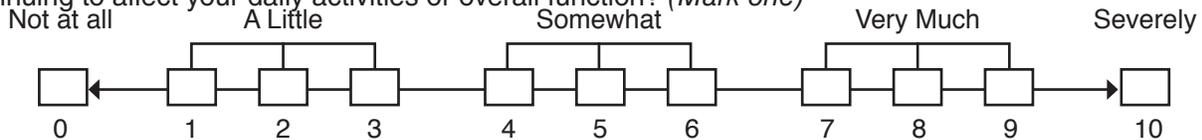
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

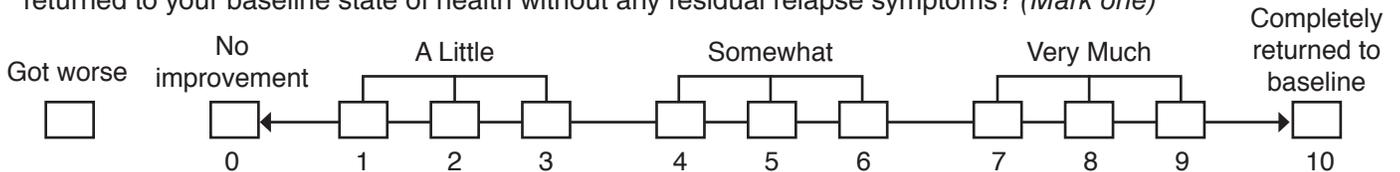
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

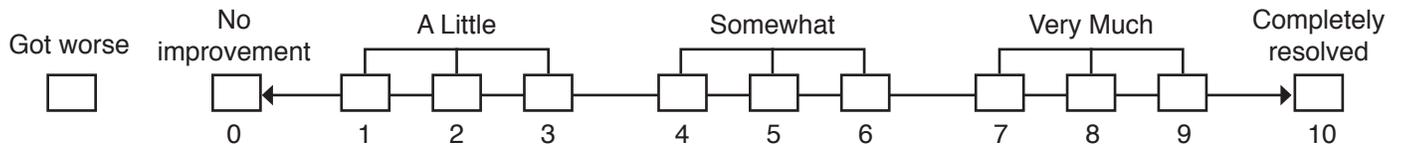
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|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

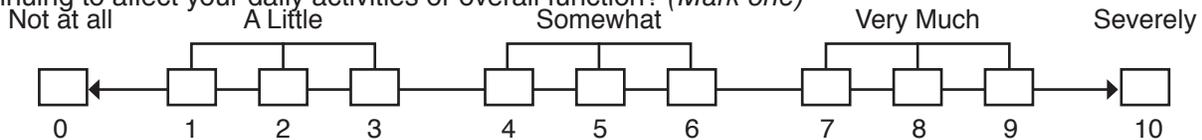
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

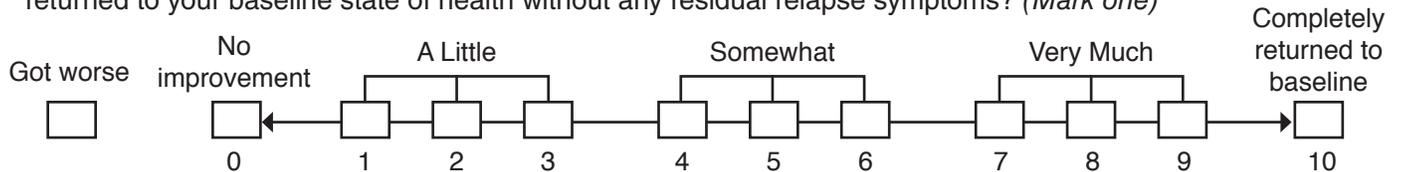
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



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|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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If you have any questions, please ask your MS Nurse

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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

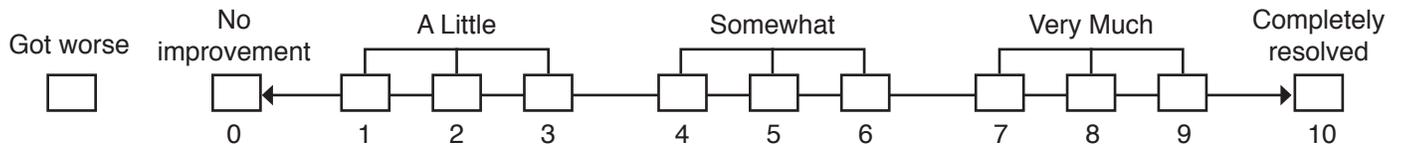
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| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

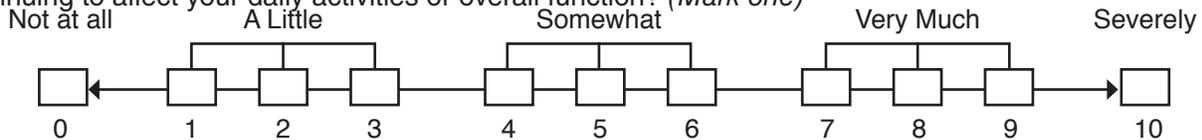
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

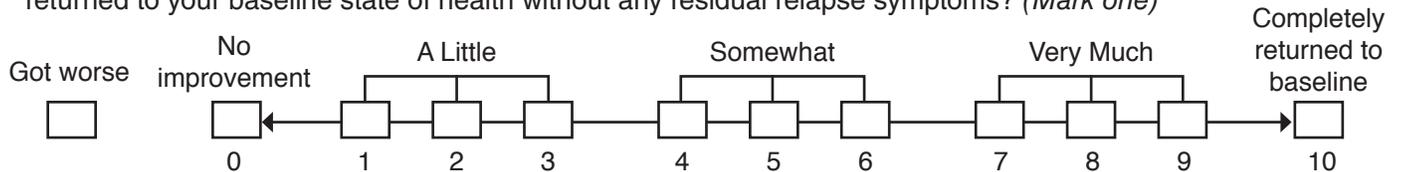
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

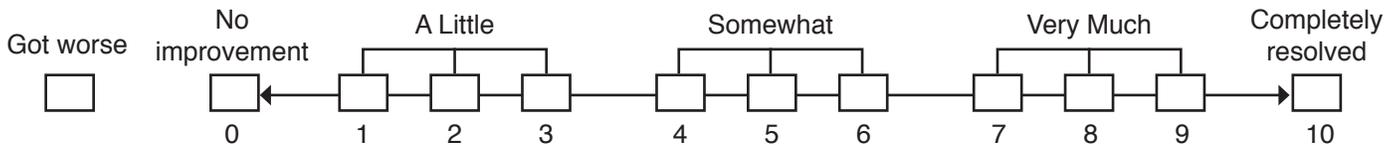
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

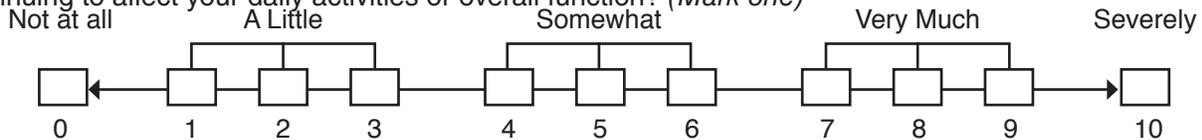
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

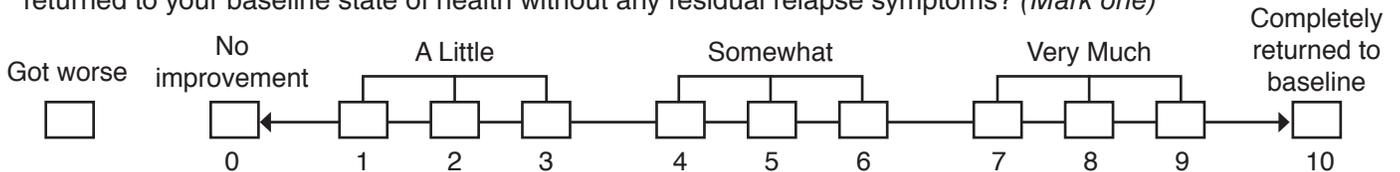
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

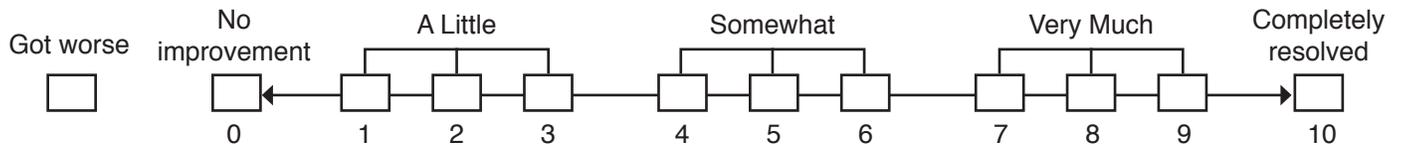
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|---|--|---|
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

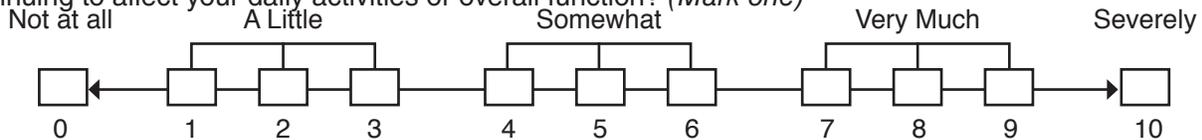
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

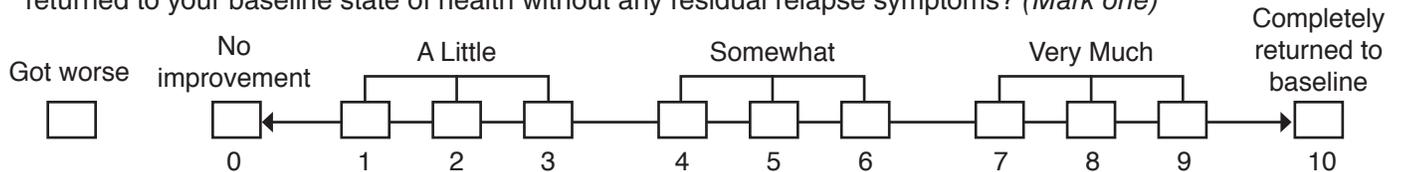
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5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

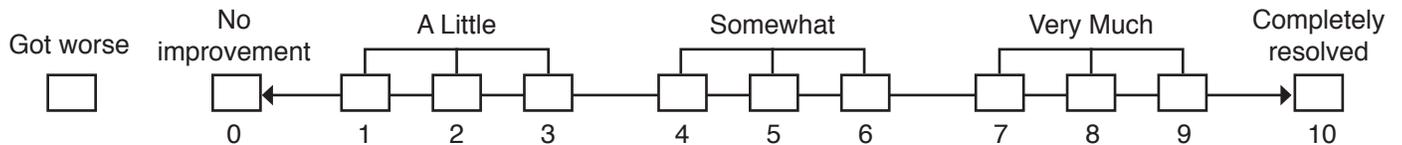
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

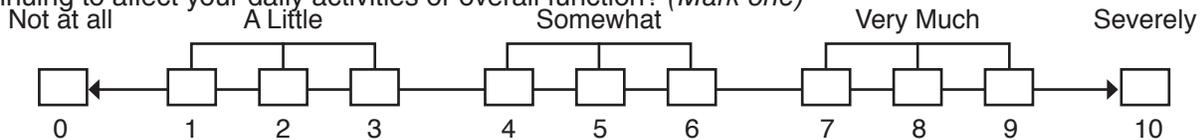
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

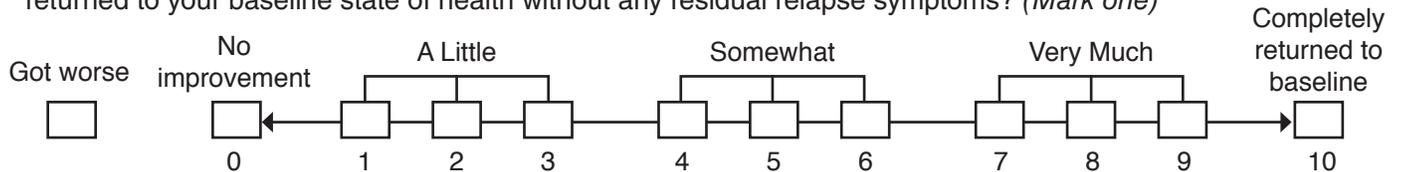
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

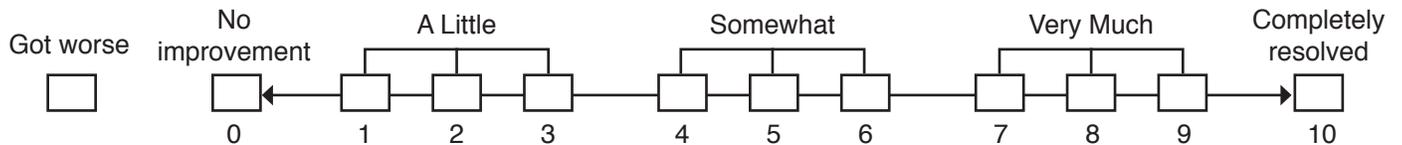
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| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

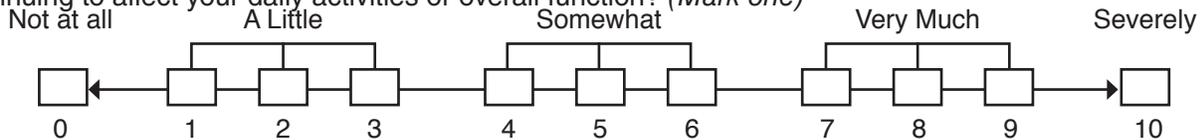
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

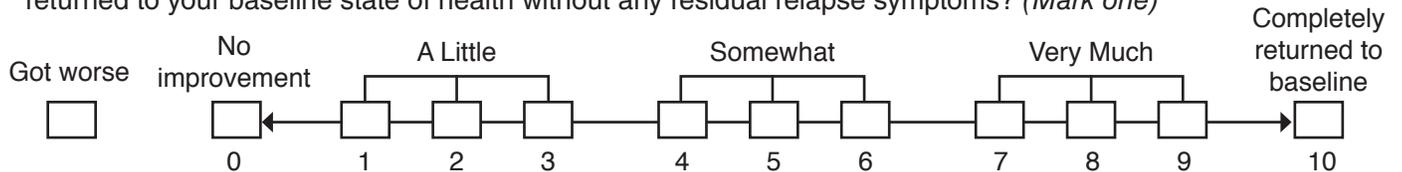
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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For office use only

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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

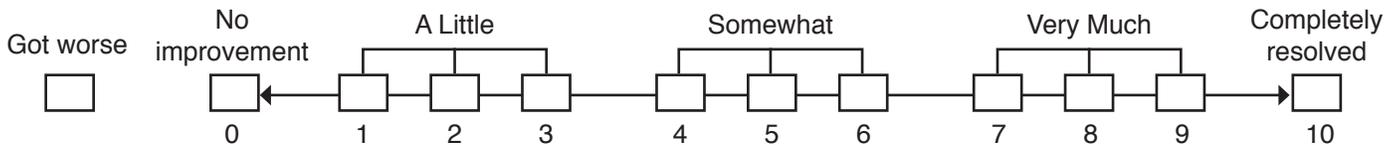
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

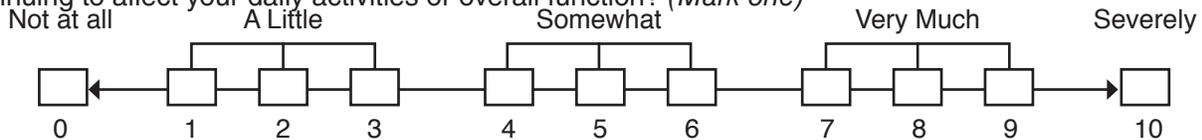
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

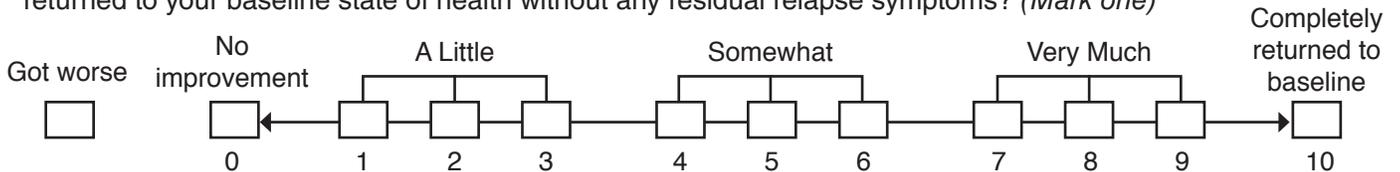
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Date: _____ Patient initials: _____

Type of MS (circle one): RRMS PPMS SPMS

Type of visit (circle one): Phone Office

Questionnaire completed by (circle one): Patient Office Staff

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

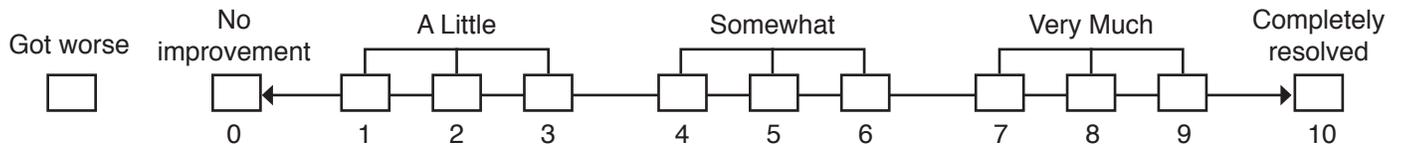
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
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2) Did you complete the prescribed relapse treatment?

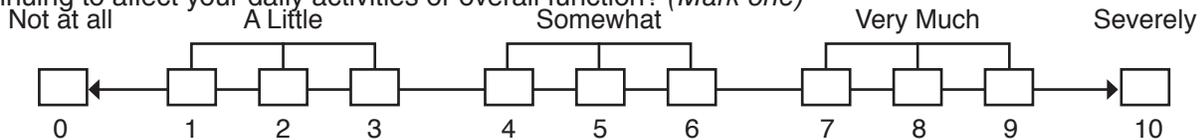
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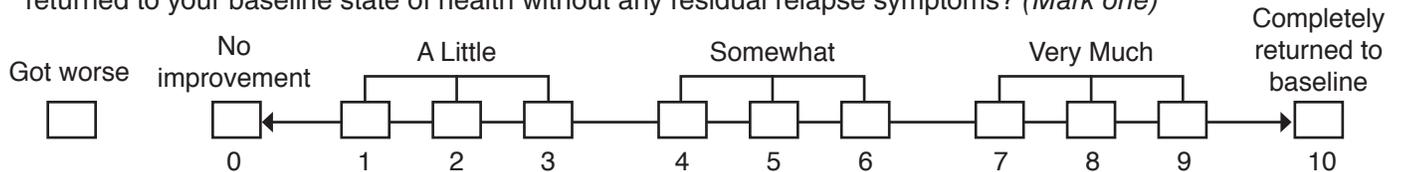
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- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Infection | <input type="checkbox"/> Other: _____ |

If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

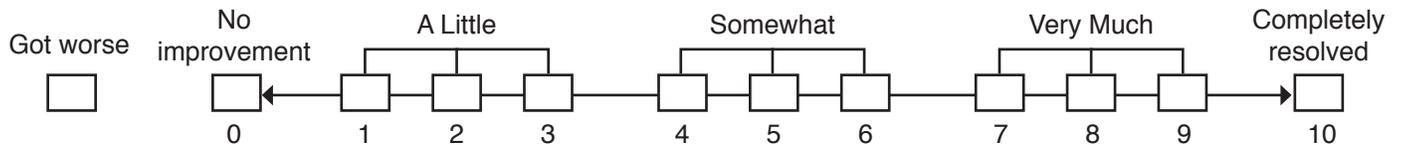
- | | | |
|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

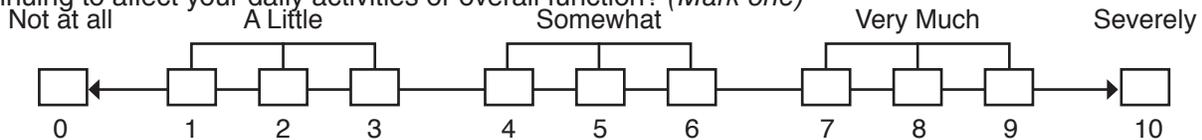
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

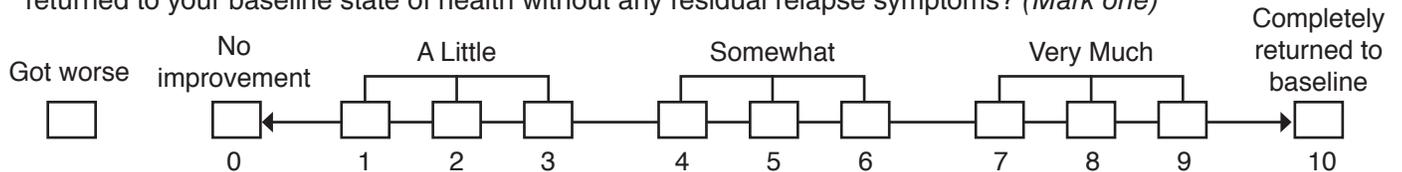
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week] follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

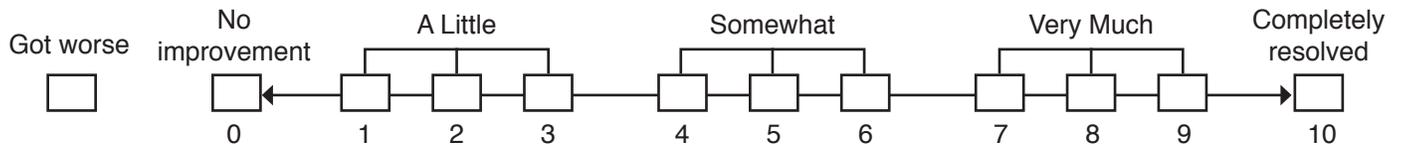
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

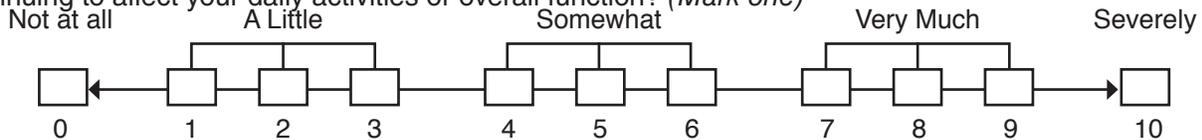
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

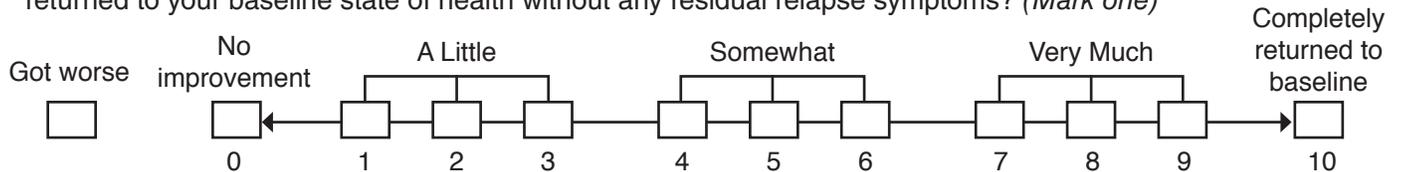
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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If you have any questions, please ask your MS Nurse

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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

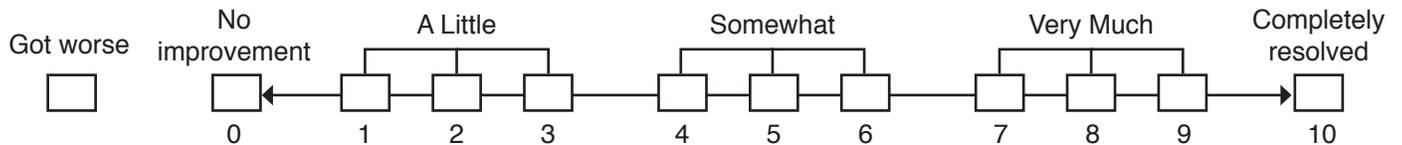
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

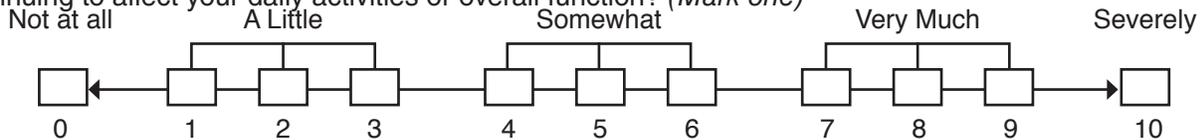
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

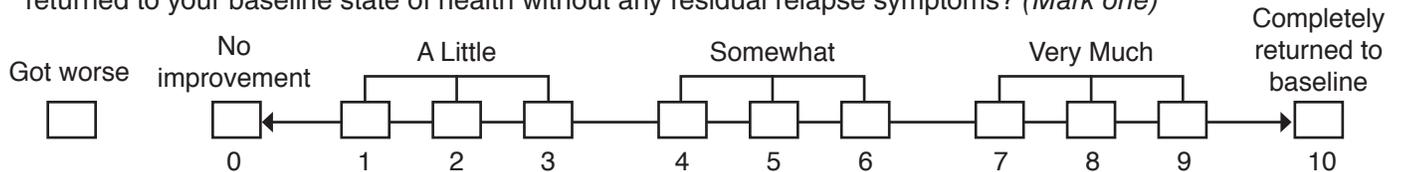
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

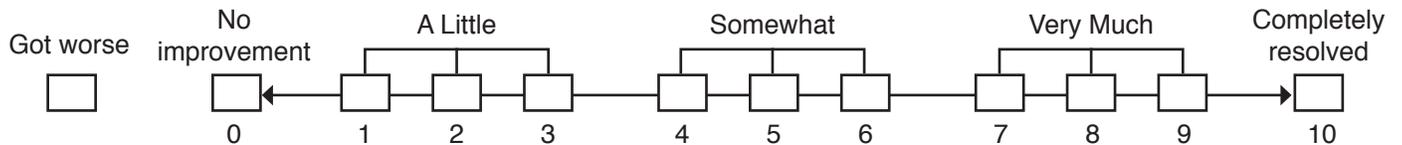
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

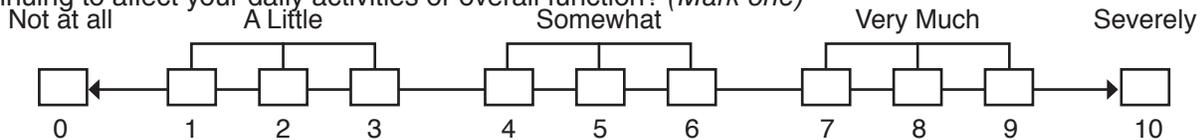
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

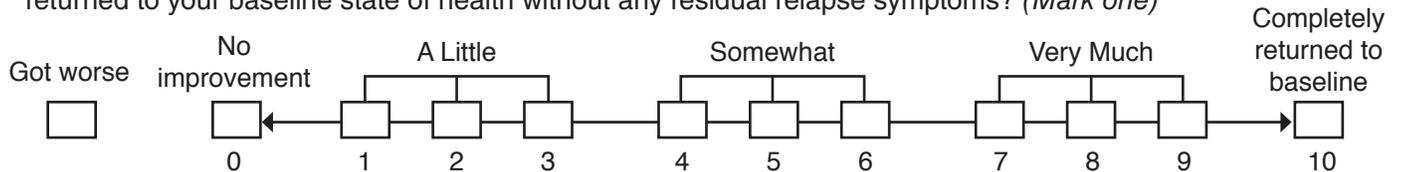
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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For office use only

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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

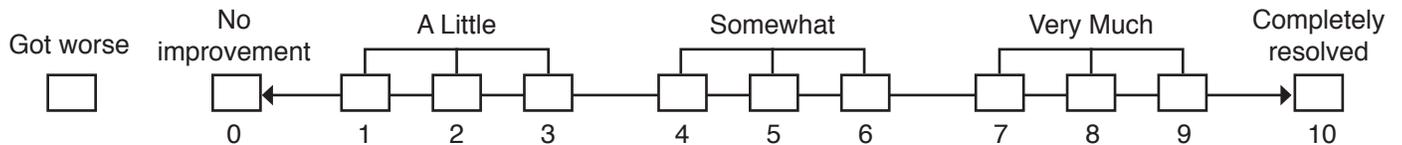
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

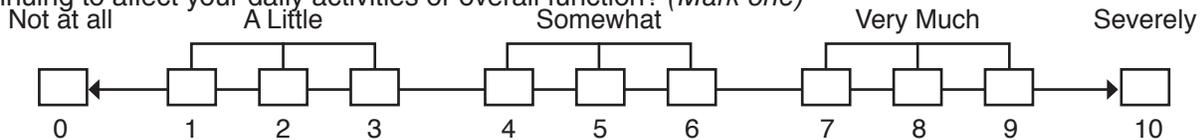
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

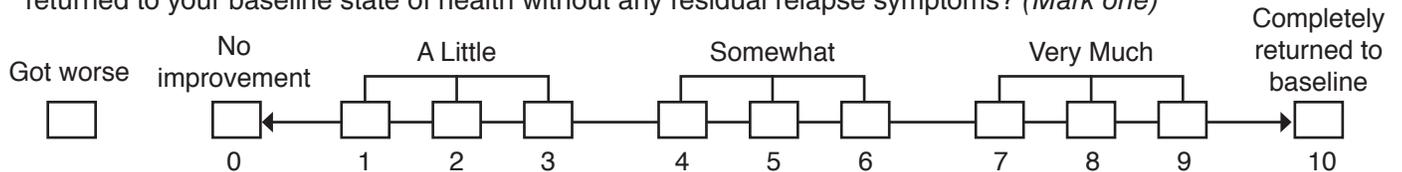
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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

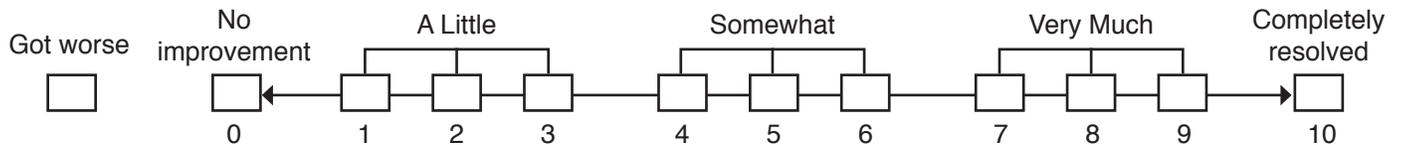
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

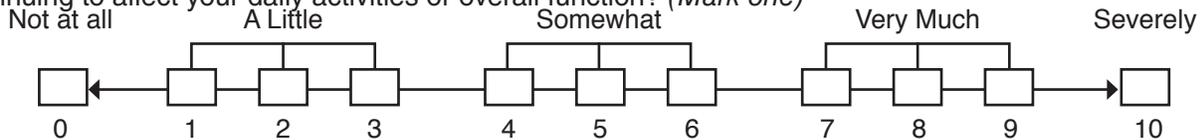
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

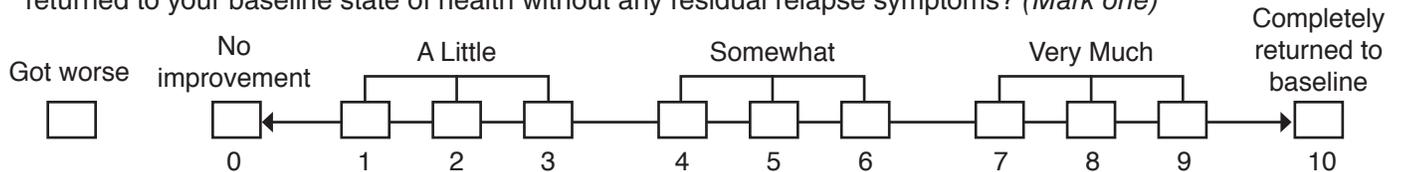
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5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

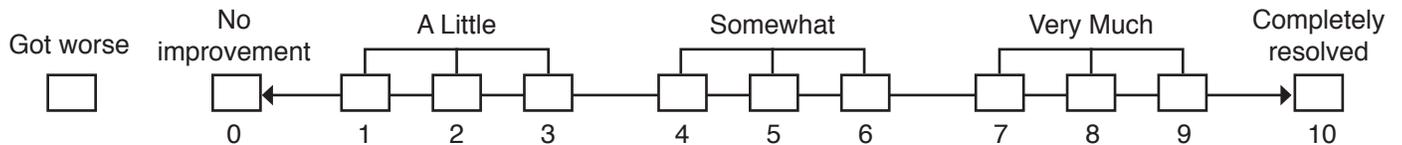
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

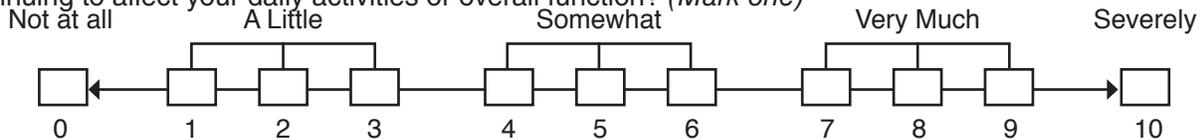
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

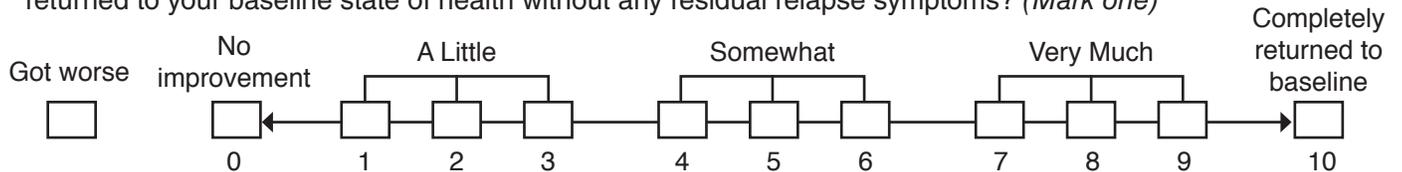
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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

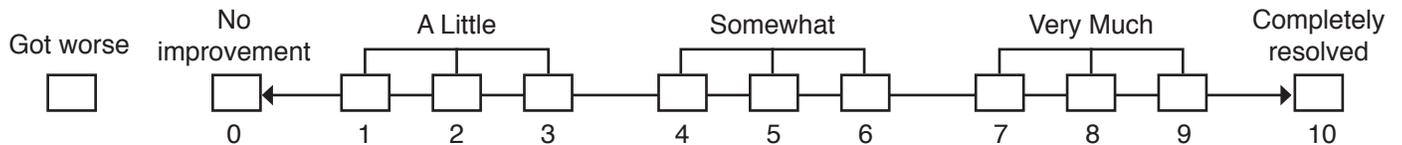
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2) Did you complete the prescribed relapse treatment?

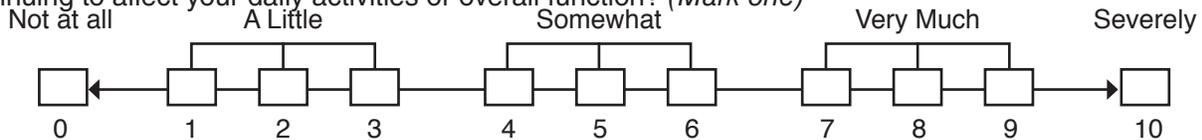
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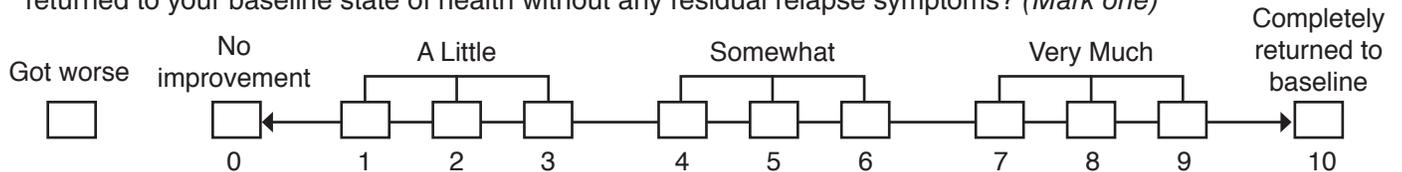
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For office use only

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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

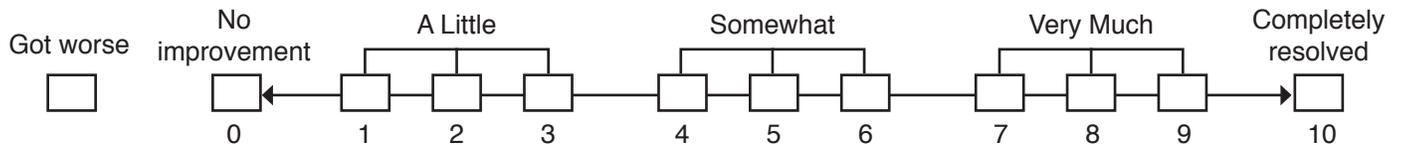
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2) Did you complete the prescribed relapse treatment?

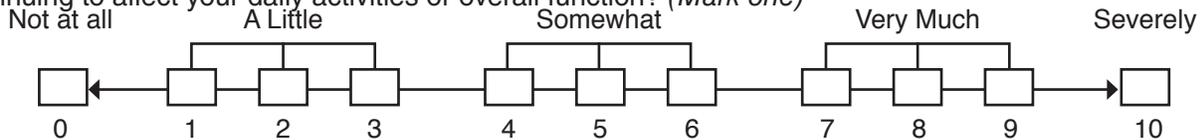
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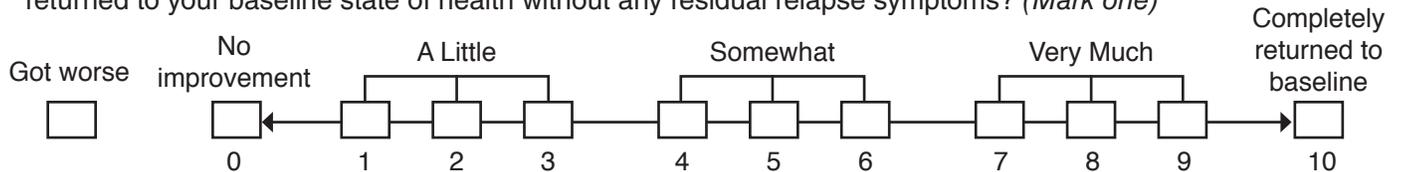
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5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Infection | <input type="checkbox"/> Other: _____ |

If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

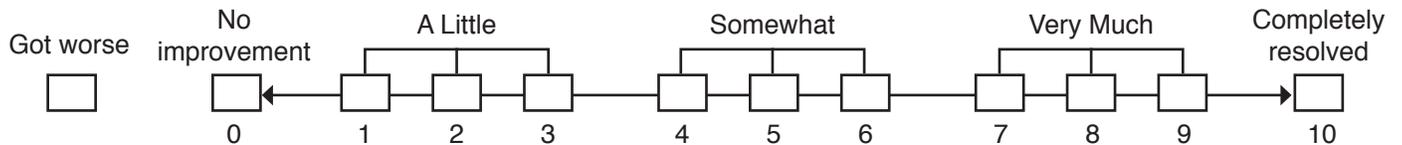
- | | | |
|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

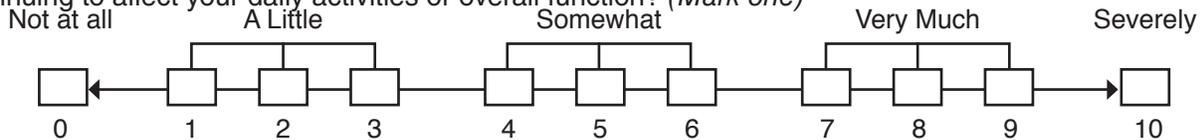
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

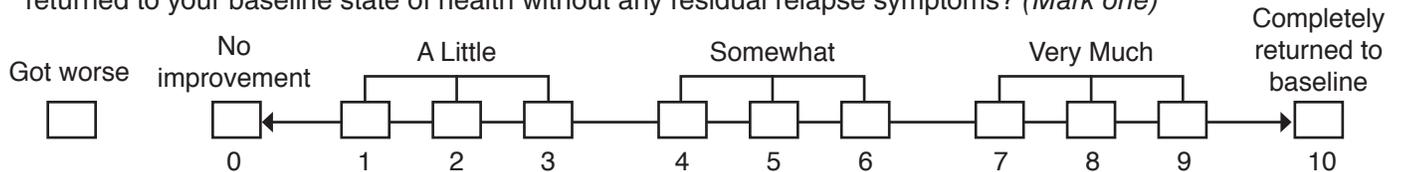
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



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7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

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|--|---|---|
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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If you have any questions, please ask your MS Nurse

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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

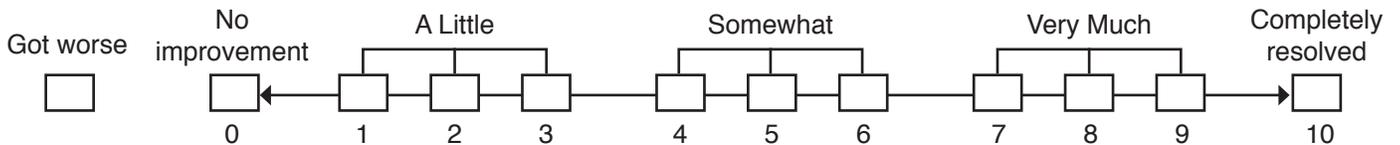
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| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

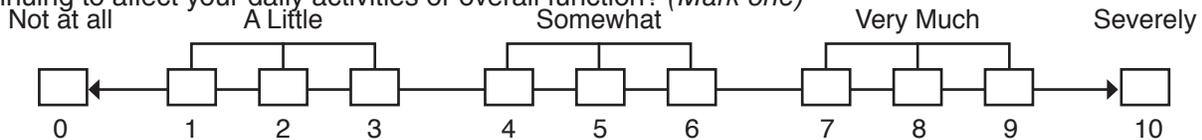
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

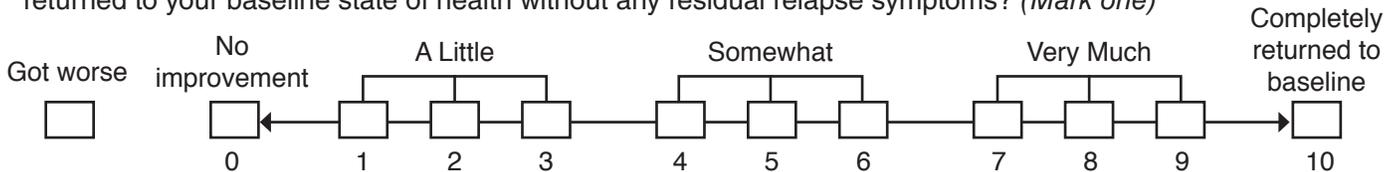
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6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



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| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

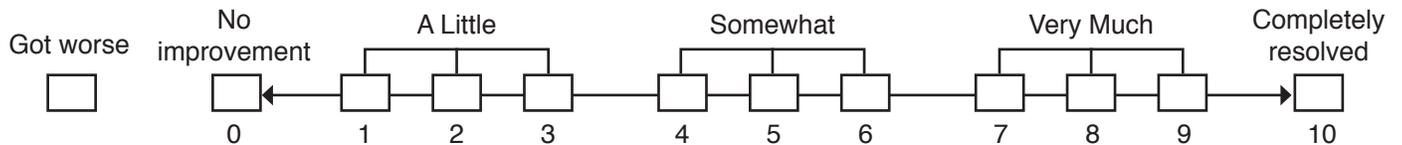
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| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

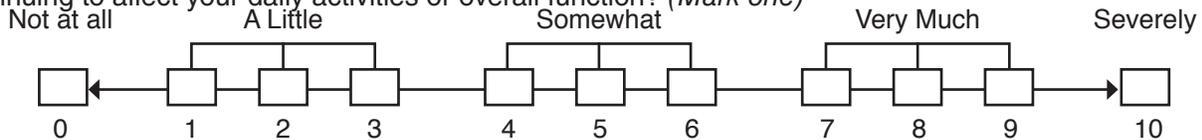
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

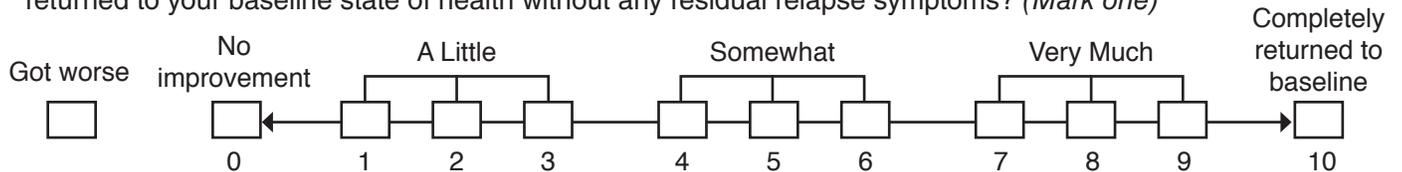
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

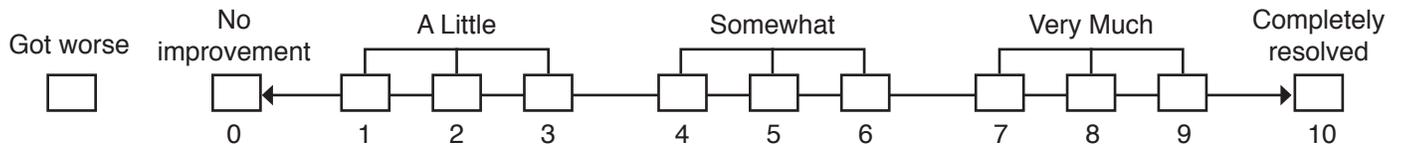
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| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

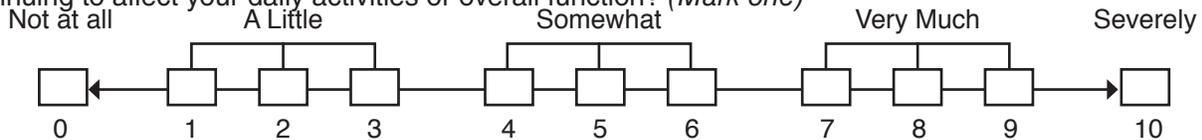
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

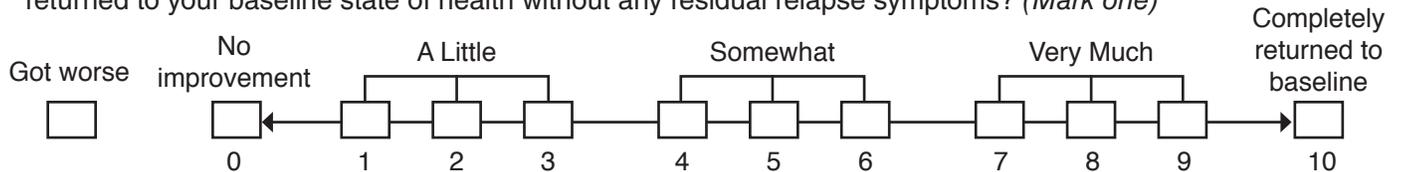
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- | | | |
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Type of visit (circle one): Phone Office

Questionnaire completed by (circle one): Patient Office Staff

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

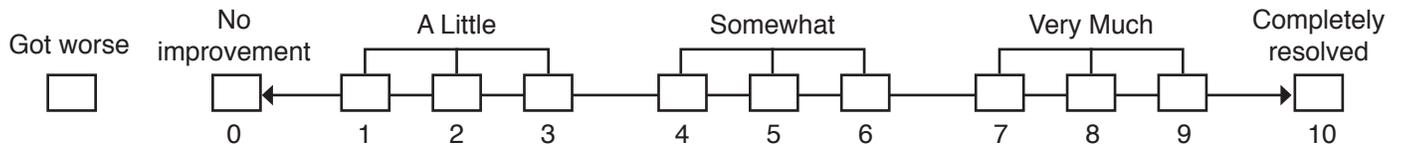
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2) Did you complete the prescribed relapse treatment?

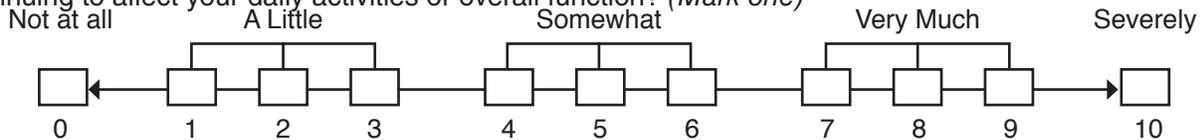
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

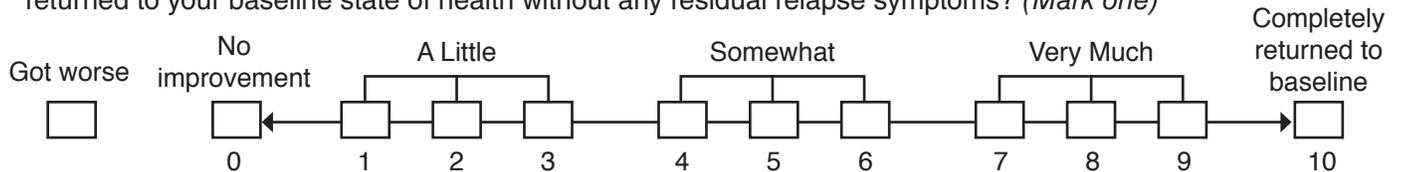
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

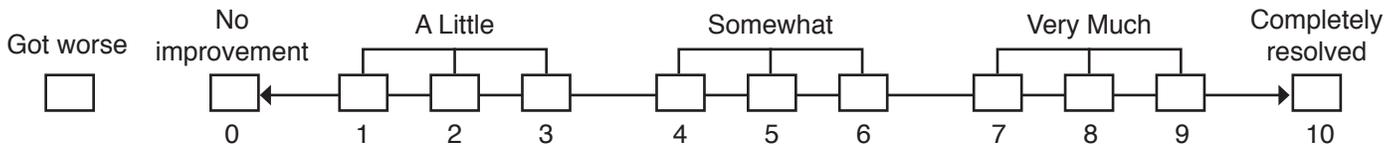
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

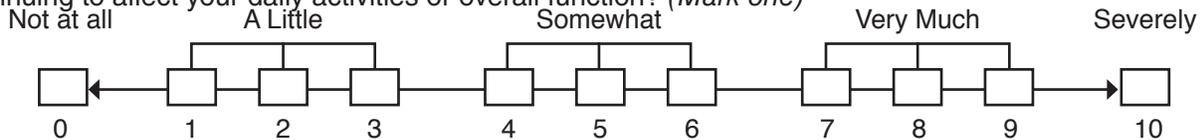
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

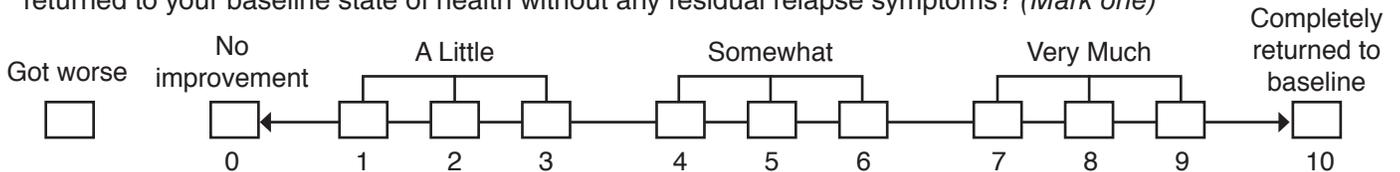
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| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

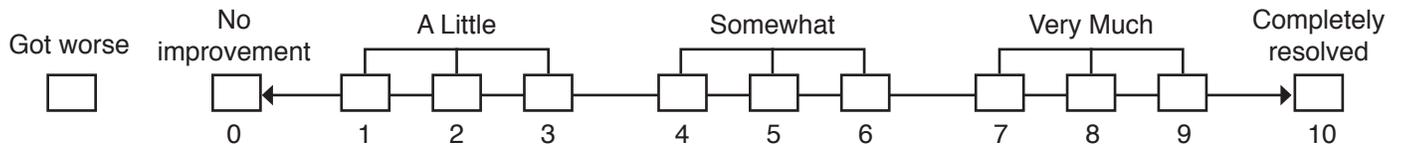
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

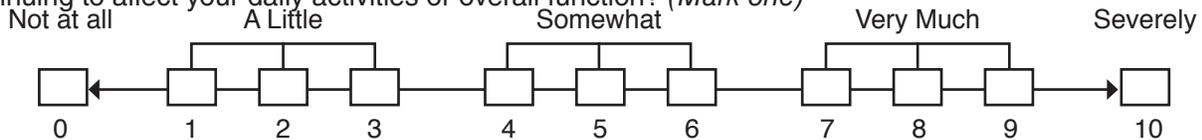
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

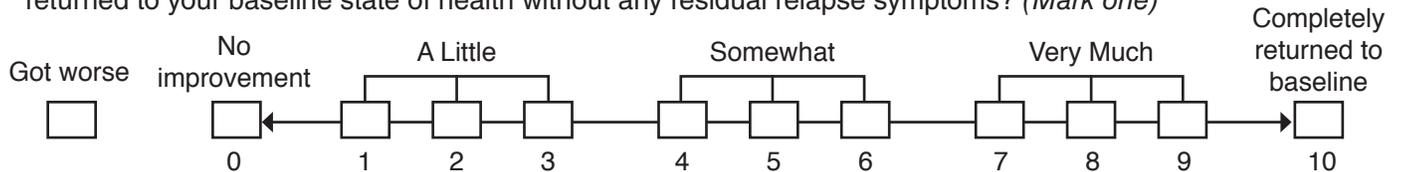
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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Date: _____ Patient initials: _____

Type of MS (circle one): RRMS PPMS SPMS

Type of visit (circle one): Phone Office

Questionnaire completed by (circle one): Patient Office Staff

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

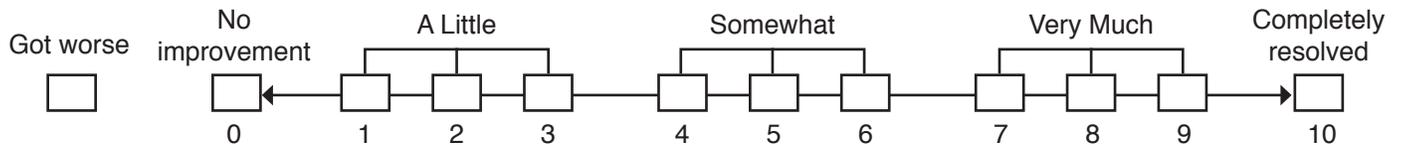
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2) Did you complete the prescribed relapse treatment?

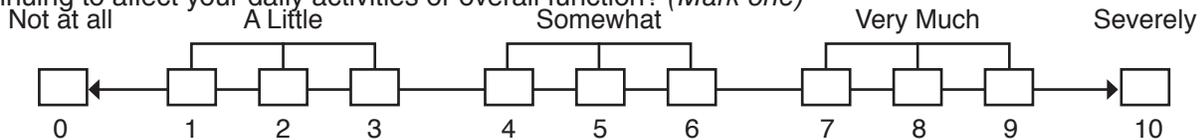
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3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

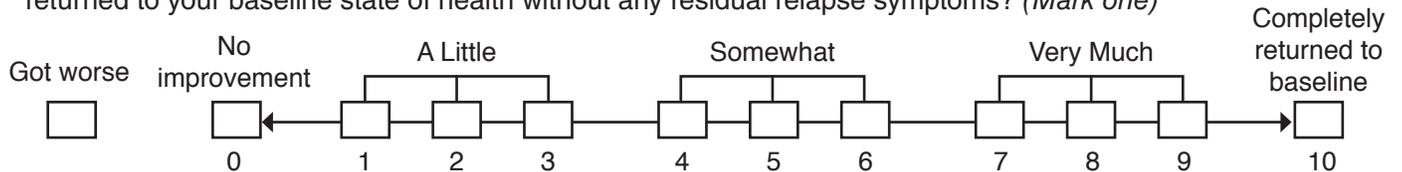
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| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

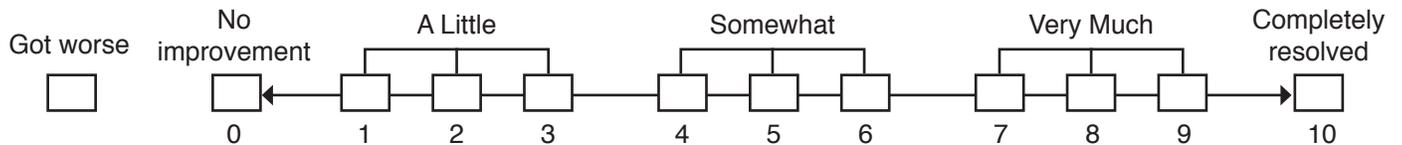
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| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

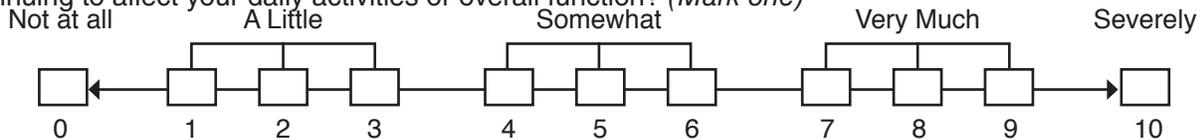
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

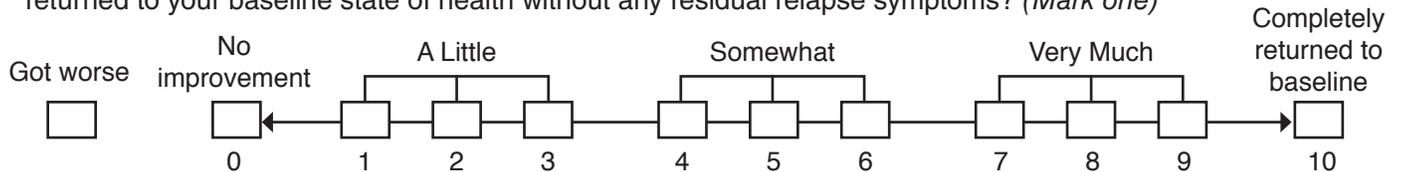
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
| <input type="checkbox"/> Sleep disturbance | <input type="checkbox"/> Increased blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Increased appetite | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps |
| <input type="checkbox"/> Chills | <input type="checkbox"/> Infection | <input type="checkbox"/> Other: _____ |

If you have any questions, please ask your MS 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

MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

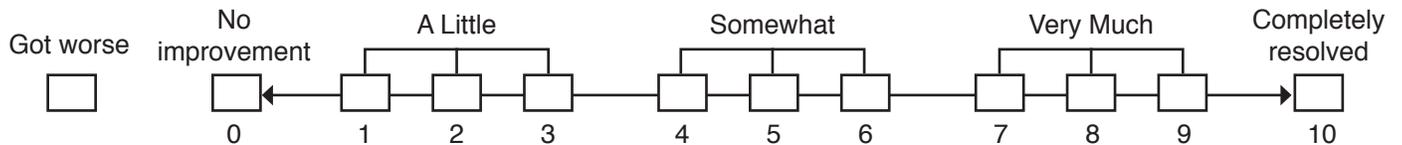
- | | | |
|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

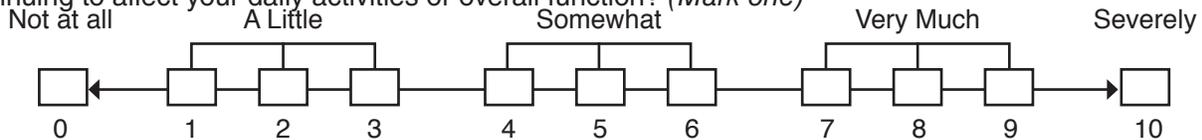
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

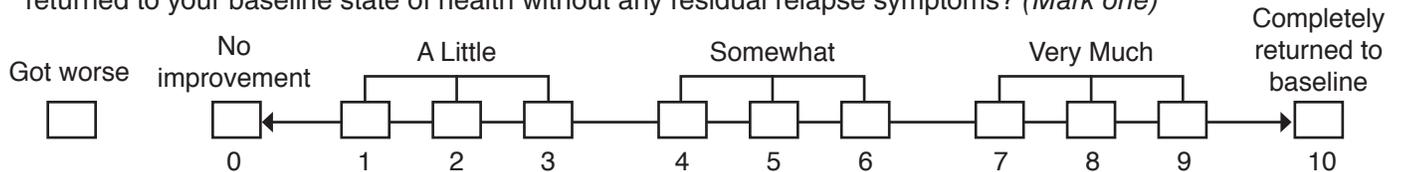
4) Do you think that the treatment for this most recent relapse (attack, exacerbation) resulted in improvement of your relapse symptoms? (Mark one)



5) Following treatment for this most recent relapse (attack, exacerbation), how much are your relapse symptoms continuing to affect your daily activities or overall function? (Mark one)



6) Following treatment for this most recent relapse (attack, exacerbation), how much do you feel that you have returned to your baseline state of health without any residual relapse symptoms? (Mark one)



7) Did you have any side effects from the treatment you received for this relapse (attack, exacerbation)? (Check all that apply)

- | | | |
|--|---|---|
| <input type="checkbox"/> Mood changes/depression/anxiety | <input type="checkbox"/> Weight gain | <input type="checkbox"/> Nausea and/or vomiting |
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| <input type="checkbox"/> Stomach upset or heartburn | <input type="checkbox"/> Headache | <input type="checkbox"/> Faintness (light headedness) |
| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

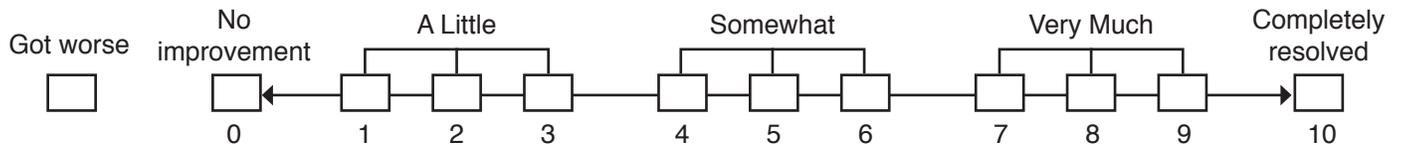
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|---|--|---|
| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
| <input type="checkbox"/> Acthar/ACTH injections | <input type="checkbox"/> Plasma exchange | <input type="checkbox"/> No treatment |
| <input type="checkbox"/> I'm not sure | <input type="checkbox"/> Other: _____ | |

2) Did you complete the prescribed relapse treatment?

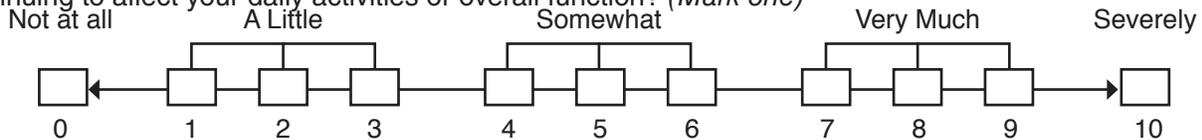
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

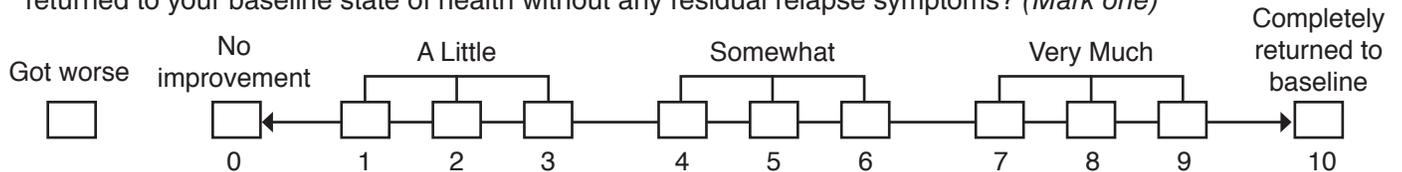
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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MS Relapse Evaluation—After Relapse Treatment (1 month \pm 1 week) follow up)

Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

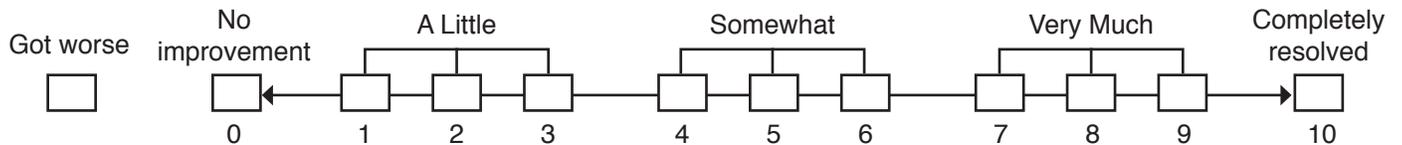
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| <input type="checkbox"/> IV steroid infusion | <input type="checkbox"/> Oral steroid tablets (only) | <input type="checkbox"/> Oral steroid tablets (after IV steroids) |
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2) Did you complete the prescribed relapse treatment?

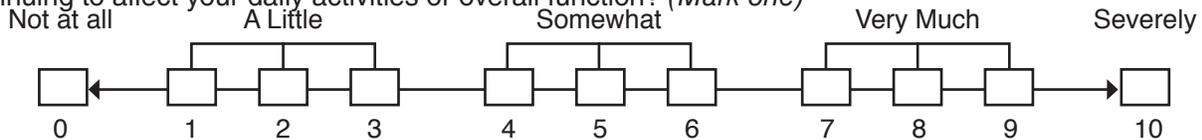
- Yes No If not, why? _____

3) How many days/months has it been since you completed treatment for this most recent relapse (attack, exacerbation)? _____

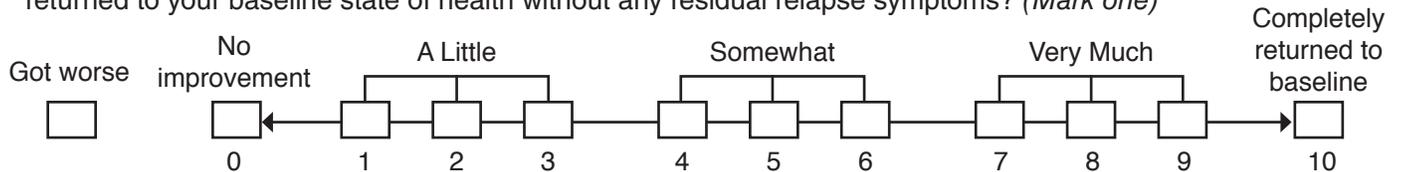
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Patient's age in years: _____

Patient's sex (circle one): Male Female

1) What treatment was prescribed for this most recent relapse (attack, exacerbation)? (Check all that apply)

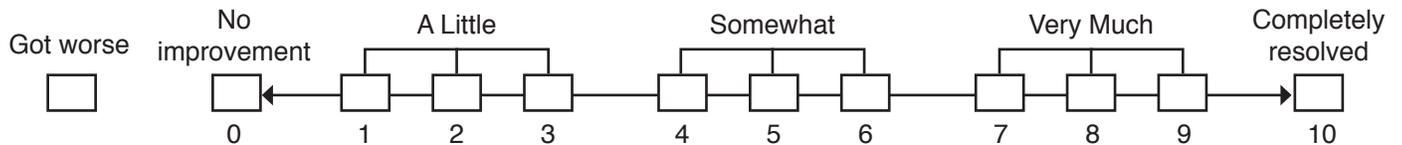
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2) Did you complete the prescribed relapse treatment?

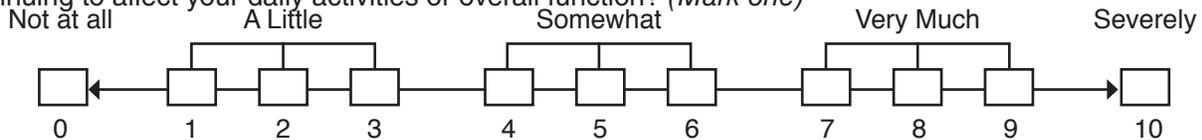
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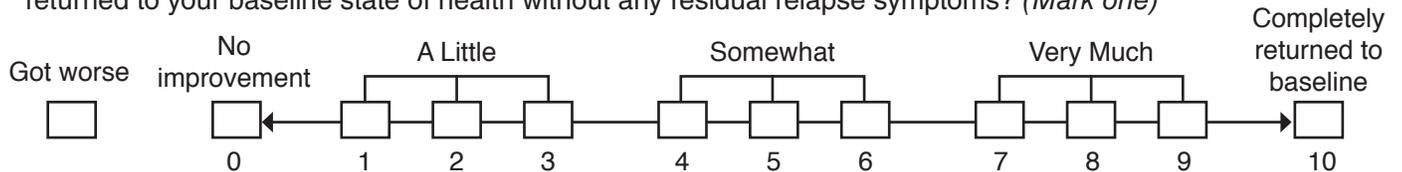
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| <input type="checkbox"/> High blood sugar | <input type="checkbox"/> Increased fatigue | <input type="checkbox"/> Dizziness |
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