Multiple Sclerosis Clinic

The Neurology Group

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Patient Name:

Date of Birth:

Date:

Would you like to sign up to receive email updates of our MS Wellness Program services?

Yes **Email Address:**

No

1. **When were you diagnosed with Multiple Sclerosis?**
2. **What were your presenting symptoms of Multiple Sclerosis?**
3. **What disease modifying therapies have you been on in the past? When/ how long were you on them? (estimation ok)**
4. **What medication on you currently on for management of you Multiple Sclerosis?**
5. **When were your most recent MRIs/ Labs/ or other diagnostic tests? Where did you have them done?**
6. **What are your most bothersome symptoms currently?**
7. **What are your overall MS goals?**

Medications Currently Taking:

Medications you have previously tried for symptom management:

Other medical problems and surgeries:

Allergies:

Social History:

Alcohol use:

Tobacco Exposure:

Other drug use:

Occupation:

Ability to perform occupation/ home duties: