Name_____

Date_____

MS ROS For Medical Visit

How far are you able to walk without a break?

_____

How is your balance?

_____

Do you have any trouble with urination?

_____

Do you have any trouble with your bowel movements?

_____

Do you have times where your speech becomes slurred or you have trouble swallowing?

_____

Do you have any memory loss or trouble concentrating on daily tasks?

_____

Do you have any physical weakness?

_____

Do you have any sensation changes, consistent pain, or tingling?

_____

Do you have any changes in your vision?

_____

Do you struggle with fatigue?

_____

Do you have any concerns of sexual dysfunction?

_____

Do you feel you struggle with feelings of depression or mood swings?

_____

Are there any other concerns or specific questions you want to address today?

_____