



# The Land of MS™ – Let us help you navigate

Make the most of your appointment!

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Date of your last visit: \_\_\_\_\_

Caregiver Name/Contact# \_\_\_\_\_

Name of your Insurance: \_\_\_\_\_

Name of Pharmacy: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Pharmacy Address: \_\_\_\_\_

Name of Primary Physician: \_\_\_\_\_

## What is the reason for your visit/Questions for your healthcare practitioner?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

## NEUROLOGICAL SYMPTOMS: (Please circle if your are experiencing)

Mobility (Movement): Abnormal gait (walking) / loss of balance/ stumbling /tripping /falling / foot drop \_\_\_\_\_

Explain Mobility issues: \_\_\_\_\_

Numbness/Tingling/Burning (where?): \_\_\_\_\_ How often? \_\_\_\_\_

Weakness (where?): \_\_\_\_\_ How often? \_\_\_\_\_

Heat or cold sensitivity (describe) \_\_\_\_\_

Double Vision/Pain with eye movements/Loss of Vision \_\_\_\_\_

Facial Drooping/Slurred Speech/Difficulty Swallowing \_\_\_\_\_

Fatigue (Yes or No) (how often?) \_\_\_\_\_

Memory—please explain \_\_\_\_\_

## List ALL Medications and Supplements (including any vitamins and herbal remedies):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

## Allergies (include your reaction):

\_\_\_\_\_  
\_\_\_\_\_

## Medication or Injection Reactions? :

Date of Last Lab work Completed? \_\_\_\_\_

Date of Last MRI? \_\_\_\_\_

Have you missed any of your regular prescribed medications or injections in the last 30 days? \_\_\_\_\_

If so why? \_\_\_\_\_

**Developed By**  
Brian Steingo, M.D.

**Provided by the MS Views and News Medical Advisory Board**  
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**Social:**

Are you currently working? (Please circle)      Full-time      Part-Time      Unemployed      Disability

Do you smoke? Yes or No (if so, what) \_\_\_\_\_ Packs per day? \_\_\_\_ For how long? \_\_\_\_\_

Have you ever quit/or tried to quit: (If so When) \_\_\_\_\_

Alcohol: (please circle) Yes or No (if so what) \_\_\_\_\_ How many drinks per day? \_\_\_\_\_

Caffeine: (please circle) Yes or No (if so what) \_\_\_\_\_ How many per day? \_\_\_\_\_

Drugs (please circle) Yes or No (if so what) \_\_\_\_\_ How often? \_\_\_\_\_

Do you exercise? (If so what type) \_\_\_\_\_ How often? \_\_\_\_\_

**Psychological:**

Please rate your average level of stress (1 being low, 5 being highest)      1   2   3   4   5

Do you need help accessing community resources like prescription assistance programs, transportation, MRI assistance programs or assistance with SSDI application? (Please circle) Yes or No

In general how do you rate your quality of life? (1 being poor, 5 being best) 1   2   3   4   5

**REVIEW OF SYMPTOMS** (Please circle the symptoms you currently have)

<p><b><u>Mental Health</u></b>                  Confusion                  Anxiety                  Depression                  Sleep Disorder                  Cognitive Issues</p>	<p><b><u>Genitourinary</u></b>                  Nighttime Urination                  Frequency                  Urgency/Incontinence                  Burning/Foul Odor                  Sexual dysfunction                  Erectile dysfunction                  Decreased libido                  Difficulty with ejaculation</p>	<p><b><u>Gastrointestinal:</u></b>                  Abdominal pain                  Nausea                  Vomiting                  Heartburn                  Diarrhea                  Constipation                  Incontinence                  Rectal Bleeding</p>	<p><b><u>Eyes:</u></b>                  Eye Pain                  Loss of Vision                  Blurred Vision                  Double Vision                  Haziness                  Infection                  Glaucoma                  Cataracts</p>
<p><b><u>Respiratory</u></b>                  Cough/wheezing                  Shortness of breath                  Snoring / Asthma</p>	<p><b><u>Constitutional Symptoms:</u></b>                  Change in Appetite                  Fever/Chills/Sweating                  Hot or Cold Intolerance                  Weight loss/Weight gain</p>	<p><b><u>Endocrine:</u></b>                  Diabetes                  Increased thirst                  Increased urination                  Thyroid disease</p>	<p><b><u>Cardiovascular</u></b>                  Hypertension                  Swelling in hands/feet                  Chest pain/palpitations                  Fainting spells</p>
<p><b><u>Hematological:</u></b>                  Bruising/bleeding                  Swollen lymph nodes</p> <p><b>OTHER:</b> (please add)</p>	<p><b><u>ENT:</u></b>                  Vertigo/dizziness                  Hoarseness / Loss of voice                  Ringing in ears                  Hearing loss                  Nasal congestion                  Post Nasal Drip</p>	<p><b><u>Musculoskeletal:</u></b>                  Joint Pain/Swelling                  Neck pain / Back pain                  Spasms/tightness                  Cramping                  Fibromyalgia                  Shooting Pains</p>	<p><b><u>Skin or Breast:</u></b>                  Breast tenderness                  Lumps/Discharge                  Pigmentation                  Dry skin                  Rash/Sores/Lesions                  Itchiness</p>

**Congratulations for being a prepared navigator through the Land of MS!**

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