The Land of MS™ – Let us help you navigate

Make the most of your neurology appointment!

Name: _____ Date: _____

Date of your last visit: _____

Name of your Insurance: _____

Name of Pharmacy: _____ Phone Number: _____

Pharmacy Address: _____

What are the reasons for your visit/Questions for your healthcare practitioner?

1._____ 2._____

3._____ 4._____

NEUROLOGICAL SYMPTOMS: (Check off all you are experiencing)

☐ Numbness/Tingling/Burning Where? _____ How often? _____

☐ Weakness Where? _____ How often? _____

☐ Vertigo/Dizziness/Balance Difficulties/Clumsiness/Difficulty Walking/Falls

☐ Double Vision/Pain with eye movements/Loss of Vision

☐ Facial Drooping/Slurred Speech/Difficulty Swallowing

☐ Fatigue How often? _____

☐ Memory Issues Details: _____

☐ Other Symptoms Details: _____

List ALL Medications and Supplements (including any vitamins and herbal remedies) **Allergies** (include your reaction)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Check here if you get a skin reaction with injections: ☐

Date of last Lab work completed: _____ Date of last MRI: _____

Check here if you have missed any of your regular prescribed medications or injections in the last 30 days ☐

If so, which ones and why? _____

Created By :
Brian Steingo, M.D.

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Working Status ☐ Full-time ☐ Part-Time ☐ Retired ☐ Unemployed ☐ Disability

Check below if you do/use any of the following:

Smoker: ☐ If so, what? _____Packs per day ____ For how long?_____

Have you ever quit/or tried to quit? If so, when? _____

Alcohol: ☐ If so, what? _____ Indicate quantity: ____ drinks per _____

Caffeine: ☐ If so, what? _____ Indicate quantity: ____ per _____

Drugs: ☐ If so, what? _____ How often? _____

Exercise: ☐ If so, describe: _____ How often? _____

Rate your average level of stress (1 being low, 5 being highest): ____

Check if you need help accessing community resources like prescription assistance programs, transportation, MRI assistance programs or assistance with SSDI application: ☐ If so, which one(s)? _____

In general how do you rate your quality of life? (1 being poor, 5 being best): ____

REVIEW OF SYMPTOMS (Please check off the symptoms you currently have)

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

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