Maine Medical PARTNERS Neurology

Adult Return Visit Questionnaire - MS Patients

Name of Patient: _____ **Date of Birth:** ____/____/_____

Primary Care Physician: Dr._____ **Today's Date:** ____/____/_____

Specific questions you would like addressed at this return visit: _____

Current Medications & Dose:

☐ **See Attached List**

☐ **Please Photocopy My List**

Name of Medication (Prescription AND Over-the-Counter)	Dose/ Strength	Number of Tablets			
		Morning	Noon	Afternoon	Bedtime

New Medical Problems (since last visit):

☐ **No Change**

Drug Allergies:

Social History Update:

☐ **No Change**

Marital Status: Married____ Single____ Divorced____ Separated____ Widowed____ Life Partnership____

Smoke? Yes_____ No_____ If yes, how much? _____/day _____/week

Alcoholic Beverages? Yes_____ No_____ If yes, how much? _____/day _____/week

Occupation: _____

****Please turn this form over and complete the back.****

Reviewed by: _____

Name: _____ Date: _____

Multiple Sclerosis Symptom Form

Please put a check mark in the field that corresponds to the severity of your symptoms. ***Circle the one problem that is of most concern that you would like addressed at today's visit.***

Symptom	Ongoing, without change	Change	Severity of Symptom		
			Mild	*Moderate*	*Severe*
Memory Problems					
Depression Mood Problems					
Sleep Problems					
Blurred or Double Vision					
Swallowing Problems					
Numbness/Tingling					
Coordination					
Fatigue					
Weakness: Arms and/or Legs					
Muscle Stiffness or Cramping					
Gait/Balance					
Bladder Problems: Frequency, Urgency, Incomplete Emptying					
Bowel Problems: Constipation, Loss of Control					
Pain, Headache					

Reviewed by: _____ Date: _____