Pre-Return Visit Questionnaire for Multiple Sclerosis

Question	Multiple Choice Option	Comments
1a	Have you had a relapse (new or worsening symptoms occurring in the absence of infection and lasting more than 24 hours) since your last visit?	Yes/no
1b	If the answer to 1a is yes, was the relapse treated with steroids?	Yes / no
2	Do you feel that your MS has progressed since your last clinic visit?	Yes / no
3a	Have you had an MRI since your last visit?	Yes / no
3b	If on a disease-modifying therapy, how many doses have you missed since your last visit?	Number: 0-30
3c	If the answer to 3a is yes, do you have side effects with the DMT?	Yes / no
4	How often do you take a vitamin D supplement?	Never Daily Weekly Monthly Other
5	How often do you use medical cannabis for your MS related symptoms?	Never Daily Weekly Monthly Other
6a	Do you have issues with your walking?	Yes/no
6b	How many falls how you had since your last visit?	#
6c	Do you have any difficulty with transferring?	Yes/no

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6d	Do you use an assistive device to help you walk / transfer?	Yes/no
6e	If the answer to 6d is yes, selected which of the following devices are used: cane walking stick, brace (AFO), walker / Rollator, scooter, wheelchair, transfer board, Hoyer lift?	Cane walking stick, brace (AFO), walker / Rollator, scooter, wheelchair transfer board, Hoyer lift
6f	How far can you walk without stopping?	Distance (drop down with unit)
6g	Do you think that your walking is worse since your last visit?	Yes/no
6h	If the answer to 6g is yes, do you think that this is of increased leg weakness, leg numbness, worsening balance, incoordination, or pain?	Increased leg weakness, increased leg numbness, worsening balance, incoordination, pain
7a	Do you have issues with your vision?	Yes/no
7b	If the answer to 7a is yes, do you think that your vision is worse since your last visit?	Yes/no
7c	If answer to 7b is yes, is this due to blurriness or double vision?	Blurriness or double vision
7d	If blurriness, is it one eye or both?	One eye Both
7e	If double vision, is it horizontal or vertical?	Horizontal Vertical

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8a	Do you have issues with fatigue?	Yes/no
8b	If answer to 8a is yes, does your fatigue feel more like sleepiness or heaviness / lassitude?	Sleepiness of heaviness / lassitude?
8c	If heaviness, have you taken a medication (amantadine or stimulant for this)?	Yes/no
8d	If sleepiness, do you snore?	Yes/no
8e	If sleepiness, are you frequently awakened by pain, spasms, or anxiety.	Pain, spasms, anxiety
9	How many times do you wake up to pee?	#
10	How many bladder infections have you had since your last visit?	1 2 3 or more
11	Do you have issues with urinary urgency?	Yes/no
12	Do you have issues initiating your urine stream or incomplete emptying of your bladder?	Yes/no
13	How often are you incontinent of urine per week?	#
14a	Do you have issues with constipation?	Yes/no
14b	If answer to 14a is yes, do you restrict fluids because of your bladder?	Yes/no
15	Do you have issues with bowel incontinence?	Yes/no

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16a	Do you have issues with sexual dysfunction?	Yes/no
16b	If answer to 16a is yes, is it related to desire, performance, fatigue, weakness, or pain?	Desire, performance, fatigue, weakness,or pain
17a	Do you have issues with your memory?	Yes/no
17b	If answer to 17a is yes, do you have issues with short-term or long term memory or both?	Short term, long term, both
17c	If answer to 17a is yes, Do you have issues finding words?	Yes/no
17d	If answer to 17a is yes, do you have issues with multi-tasking?	Yes/no
18a	Are you working?	Yes/no
18b	If answer to 18a is yes, is memory, fatigue, weakness, or pain affecting your ability to do your job	Memory, fatigue, weakness, pain
18c	If answer to 18a is no, do you have (or are you applying) for disability?	Yes/no/applying
19a* *19a-c may be excluded if PHQ also being administered to the patient	Do you have issues with depression?	Yes/no

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19b	If you have issues with depression, do you still enjoy doing things that you used to enjoy?	Yes/No
19c	Do you have thoughts or hurting yourself or others?	Yes/no
20	Do you have issues with anxiety?	Yes/no
21a	Do you have pain?	Yes/no
21b	If answer to 21a is yesyou're your pain under control?	Yes/no
21c	If answer to 21a is yes, is it burning, pins / needles, electrical pain?	Yes/no
21d	If answer to 21a is yes, is it joint pain or does it worsen with certain movements?	Yes/no
21e	If answer to 21a is yes, is it facial pain?	Yes/no
21f	Do you ever get an electric sensation going down your back when you flex your neck forward?	Yes/no
22	Do you have a tremor or incoordination?	Yes/no

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