Date: ________________________________ **GP/Walk-in clinic**: ______________________

Name: _________________________________ Height: __________ Weight: __________

Follow-Up Symptoms

This form is intended to provide the healthcare team with information about your current concerns.

1. Top three concerns to be addressed during today's visit:

1.	2.	3.

2. Have you had any new diagnoses since your last visit?
   [ ] No
   [ ] Yes ____

3. Has there been a change in your medications since your last visit?
   [ ] No
   [ ] Yes ____

4. List current medications/dosage:

5. Since your last visit, have you experienced problems with:

[ ] Vision
[ ] Fatigue
[ ] Bladder
[ ] Bowel
[ ] Speech
[ ] Hearing
[ ] Memory (short/long term)
[ ] Mood and thought disturbances
[ ] Muscle spasticity/stiffness
[ ] Pain
[ ] Sexual function
[ ] Relapse (appearance of new or worsening of old symptoms lasting at least 24 hours)

[ ] Climbing/descending stairs
[ ] Mobility
[ ] Transfers
[ ] Bathing
[ ] Grooming
[ ] Dressing
[ ] Feeding
[ ] Coordination
[ ] Balance

For those on injectable drugs:
[ ] Problems at injection site
[ ] Side-effects
[ ] Missed injection