# Multiple Sclerosis Assessment Tool

Name: ____________________________

Last 4: __ __ __ __

Date: ___ / ___ / ______

Assessment Type:
- □ Baseline
- □ Annual
- □ Interim
- □ Medications Only

Interview completed by:
- □ Telephone
- □ Clinical Video Teleconference
- □ In-person Assessment

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1. Race, as defined by patient:
   - □ American Indian or Alaskan Native
   - □ Asian
   - □ Black or African American
   - □ Native Hawaiian or other Pacific Islander
   - □ White
   - □ Other: ____________________________

2. Ethnicity, as defined by patient:
   - □ Hispanic
   - □ Not Hispanic

3. Gender:
   - □ Male
   - □ Female

4. Biological family history of Multiple Sclerosis:
   - □ Unknown
     - Comment: ____________________________
   - □ None
   - □ Yes
     - □ Mother
     - □ Father
     - □ Daughter
     - □ Son
     - □ Sister
     - □ Brother
     - □ Other: ____________________________

5. Biological family history of clinically isolated syndrome:
   - □ Unknown
     - Comment: ____________________________
   - □ None
   - □ Yes
     - □ Mother
     - □ Father
     - □ Daughter
     - □ Son
     - □ Sister
     - □ Brother
     - □ Other: ____________________________
6. Biological family history of neuromyelitis optica/Devic’s disease:
   □ Unknown
   Comment: ________________________________
   □ None
   □ Yes
      □ Mother
      □ Father
      □ Daughter
      □ Son
      □ Sister
      □ Brother
      □ Other: _____________________________

7. Diagnosis History:
   □ Multiple Sclerosis
      Date of first neurological sign/symptom (if known): ____________
      Date of MS diagnosis: ____________
   □ Possible Multiple Sclerosis
   □ Clinically Isolated Syndrome (CIS)
      Date of first sign/symptom (if known): ____________
   □ Neuromyelitis Optica/Devic’s Disease (NMO)
      Date of first neurological sign/symptom (if known): ____________
      Date of NMO diagnosis: ____________
   □ Determined NOT to have Multiple Sclerosis
      Comment: ________________________________

8. Type of initial MS/NMO symptom (check all that apply):
   □ Motor
   □ Sensory
   □ Brainstem
   □ Cerebellar
   □ Optic Neuritis
   □ Cognitive
   □ Bowel/Bladder
   □ Spinal Cord

9. Multiple Sclerosis Subtype:
   □ Relapsing-Remitting (RRMS)
   □ Secondary Progressive (with or without relapses) (SPMS)
      Date of transition to SPMS (if known): ____________
   □ Primary Progressive (PPMS)
   □ Progressive-Relapsing (PRMS)
   □ Not applicable (CIS or NMO)

10. MS Service-Connection Status:
    □ Patient is service-connected for MS
    □ Patient is not service-connected for MS
11. Current MS or NMO Disability:
   □ 1 = No disability: minimal signs on neurological examination
   □ 2 = Minimal and not ambulation-related disability; able to run
   □ 3 = Unlimited walking distance without rest but unable to run, or a significant not ambulation-related disability
   □ 4 = Walks without aid; limited walking distance, but greater than 500 meters without rest
   □ 5 = Walks without aid; walking distance less than 500 meters without rest
   □ 6a = Walks with permanent unilateral support; walking distance less than 100 meters without rest
   If applicable, year patient reached an EDMUS disability score of 6 (walks with unilateral or bilateral support)
   □ 6b = Walks with permanent bilateral support; walking distance less than 100 meters without rest
   □ 7 = Home-restricted; a few steps with wall or furniture assistance; walking distance less than 20 meters without rest
   □ 8 = Chair-restricted; unable to take a step; some effective use of arms
   If applicable, year patient reached an EDMUS disability score of 8 (restricted to chair)
   □ 9 = Bedridden and totally helpless
   □ 10 = Death due to MS

12. Number of relapses* over the past 12 months:

   *relapse = worsening neurological symptoms for > 24hrs that stabilize or resolve

13. MS or NMO medications (for baseline, be sure to document ALL medications):

   **Azathioprine (Imuran)**
   □ Never taken
   □ Current use
     □ VA Pharmacy
     □ Non-VA Pharmacy
     Approximate date started: ____________
   □ Past Use
     □ VA Pharmacy
     □ Non-VA Pharmacy
     Approximate date started: ____________
     Approximate date stopped: ____________
     Reason Stopped:
     □ Ineffective
     □ Intolerance to medication (e.g. leukopenia, allergic reaction, nausea/vomiting)
     □ Significant adverse event: ____________________________

   **Cyclophosphamide (Cytoxan)**
   □ Never taken
   □ Current use
     □ VA Pharmacy
     □ Non-VA Pharmacy
     Approximate date started: ____________
   □ Past Use
     □ VA Pharmacy
     □ Non-VA Pharmacy
     Approximate date started: ____________
     Approximate date stopped: ____________
     Reason Stopped
     □ Ineffective
     □ Intolerance to medication (e.g. cystitis, leukopenia, nausea/vomiting)
     □ Significant adverse event: ____________________________
Daclizumab (Zenapax)
☐ Never taken
☐ Current use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
☐ Past Use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
   Approximate date stopped: __________
Reason Stopped
   ☐ Ineffective
   ☐ Intolerance to medication (e.g. cystitis, leukopenia, nausea/vomiting)
   Adverse events
      ☐ Blood count abnormal
      ☐ Rash/Allergic reaction
      ☐ Immunosuppression-related complication
      ☐ Other significant adverse event: __________________________

Dimethyl Fumerate (Tecfidera)
☐ Never taken
☐ Current use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
☐ Past Use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
   Approximate date stopped: __________
Reason Stopped
   ☐ Ineffective
   ☐ Intolerance to medication (e.g. nausea, flushing, infection)
   ☐ Significant adverse event: __________________________

Fingolimod (Gilenya)
☐ Never taken
☐ Current use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
☐ Past Use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
   Approximate date stopped: __________
Reason Stopped
   ☐ Ineffective
   ☐ Intolerance to medication (e.g. cardiac toxicity, infection, macular edema)
   ☐ Significant adverse event: __________________________
Glatiramer (Copaxone)
☐ Never taken
☐ Current use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
☐ Past Use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
   Approximate date stopped: __________
Reason Stopped
   ☐ Ineffective
   ☐ Intolerance to medication (e.g. injection site reaction, chest pain, rash)
   ☐ Significant adverse event: __________________________________________

Interferon Group
Neutralizing Interferon Antibody status:
☐ Positive
   Date: __________
☐ Negative
   Date: __________
☐ Unknown

Interferon beta-1a (Avonex)
☐ Never taken
☐ Current use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
☐ Past Use
   ☐ VA Pharmacy
   ☐ Non-VA Pharmacy
   Approximate date started: __________
   Approximate date stopped: __________
Reason Stopped
   ☐ Ineffective
   ☐ Intolerance to medication (e.g. injection site reaction, flu-like symptoms, depression)
   ☐ Significant adverse event: __________________________________________
Interferon beta-1a (Rebif)

☐ Never taken
☐ Current use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
☐ Past Use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
  Approximate date stopped: __________
Reason Stopped
  ☐ Ineffective
  ☐ Intolerance to medication (e.g. Injection site reaction, flu-like symptoms, depression)
  ☐ Significant adverse event: ______________________________

Interferon beta-1b (Betaseron)

☐ Never taken
☐ Current use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
☐ Past Use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
  Approximate date stopped: __________
Reason Stopped
  ☐ Ineffective
  ☐ Intolerance to medication (e.g. Injection site reaction, flu-like symptoms, depression)
  ☐ Significant adverse event: ______________________________

Interferon beta-1b (Extavia)

☐ Never taken
☐ Current use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
☐ Past Use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
  Approximate date stopped: __________
Reason Stopped
  ☐ Ineffective
  ☐ Intolerance to medication (e.g. Injection site reaction, flu-like symptoms, depression)
  ☐ Significant adverse event: ______________________________
Methotrexate (Trexall/Rheumatrex)

- Never taken
- Current use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
- Past Use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
    - Approximate date stopped: __________
  - Reason Stopped
    - Ineffective
    - Intolerance to medication (e.g. stomatitis, leukopenia, nausea)
    - Significant adverse event: ______________________________

Mitoxantrone (Novantrone)

- Patient is being monitored for cardiotoxicity
  - Date of most recent cardiac MUGA or Echocardiogram: _________________
  - Date of last cardiac MUGA or Echocardiogram unknown
- Never taken
- Current use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
    - Number of doses taken: __________
- Past Use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
    - Approximate date stopped: __________
    - Number of doses taken: __________
  - Reason Stopped
    - Maximum dose reached
    - Ineffective
    - Intolerance to medication (e.g. diminished cardiac ejection fraction, infection, nausea)
    - Significant adverse event: ______________________________

Mycophenolate Mofetil (Cellcept)

- Never taken
- Current use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
- Past Use
  - VA Pharmacy
  - Non-VA Pharmacy
    - Approximate date started: __________
    - Approximate date stopped: __________
  - Reason Stopped
    - Ineffective
    - Intolerance to medication (e.g. leukopenia, peripheral edema, hematuria)
    - Significant adverse event: ______________________________
Natalizumab (Tysabri)
Serum anti-JC virus antibody status
- □ Negative
  - Date: __________
- □ Positive
  - Date: __________
- □ Unknown
- □ Never taken
- □ Current use
  - □ VA Pharmacy
  - □ Non-VA Pharmacy
    - Approximate date started: __________
    - Number of doses taken: __________
- □ Past Use
  - □ VA Pharmacy
  - □ Non-VA Pharmacy
    - Approximate date started: __________
    - Approximate date stopped: __________
    - Number of doses taken: __________
  - Reason Stopped
    - □ Ineffective
    - □ Intolerance to medication (e.g. allergic reaction, infection, abnormal liver enzymes)
    - □ Serum JC antibody positive
    - □ Significant adverse event: ________________________________

Rituximab (Rituxan)
- □ Never taken
- □ Current use
  - □ VA Pharmacy
  - □ Non-VA Pharmacy
    - Approximate date started: __________
    - Number of doses taken: __________
- □ Past Use
  - □ VA Pharmacy
  - □ Non-VA Pharmacy
    - Approximate date started: __________
    - Approximate date stopped: __________
    - Number of doses taken: __________
  - Reason Stopped
    - □ Treatment cycle completed
    - □ Ineffective
    - □ Intolerance to medication (e.g. infusion reaction, infection, leukopenia)
    - Adverse events
      - □ Blood count abnormal
      - □ Rash/Allergic reaction
      - □ Immunosuppression-related complication: _______________________
      - □ Other significant adverse event: ________________________________
Other DMTs: ____________________________

☐ Never taken
☐ Current use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
☐ Past Use
  ☐ VA Pharmacy
  ☐ Non-VA Pharmacy
  Approximate date started: __________
  Approximate date stopped: _________
Reason Stopped
  ☐ Maximum dose reached
  ☐ Ineffective
  ☐ Intolerance to medication
  ☐ Significant adverse event: ____________________________

Corticosteroids (only include those used for maintenance therapy, not relapse therapy)

☐ Never taken
☐ Current use

IV Route
  ☐ Dexamethasone IV (Decadron)
    ☐ VA Pharmacy
    ☐ Non-VA Pharmacy
    ☐ Monthly schedule
    ☐ Other schedule: ___________________
    Approximate date started: __________
  ☐ Methylprednisolone IV (Solumedrol)
    ☐ VA Pharmacy
    ☐ Non-VA Pharmacy
    ☐ Monthly schedule
    ☐ Other schedule: ___________________
    Approximate date started: __________

Oral Route
  ☐ Methylprednisolone PO (Medrol)
    ☐ VA Pharmacy
    ☐ Non-VA Pharmacy
    ☐ Monthly schedule
    ☐ Other schedule: ___________________
    Approximate date started: __________
  ☐ Prednisone PO
    ☐ VA Pharmacy
    ☐ Non-VA Pharmacy
    ☐ Monthly schedule
    ☐ Other schedule: ___________________
    Approximate date started: __________
Past Use

IV Route
- Dexamethasone IV (Decadron)
  - VA Pharmacy
  - Non-VA Pharmacy
  - Monthly schedule
  - Other schedule: ___________________
  - Approximate date stopped: __________
- Methylprednisolone IV (Solumedrol)
  - VA Pharmacy
  - Non-VA Pharmacy
  - Monthly schedule
  - Other schedule: ___________________
  - Approximate date stopped: __________

Oral Route
- Methylprednisolone PO (Medrol)
  - VA Pharmacy
  - Non-VA Pharmacy
  - Monthly schedule
  - Other schedule: ___________________
  - Approximate date stopped: __________
- Prednisone PO
  - VA Pharmacy
  - Non-VA Pharmacy
  - Monthly schedule
  - Other schedule: ___________________
  - Approximate date stopped: __________