

Name, first name:

Form filled by:

Birth date:

Validated by:

CLINICAL ASSESSMENT

Date of exam : Day Month Year

Concurrent relapse Functional participation
 Pseudo-exacerbation

Scales

Ambulation

Able to run: Yes / No

Walking distance without rest: Unlimited >500 m 300-500 200-300 100-200 20-100 <20 m

Assistance required: Unilateral / bilateral / wheelchair / motorized wheelchair

EGS (EDMUS Grading Scale)

EDSS (Kurtzke)

Kurtzke functional systems

Pyramidal Brainstem
 Cerebellar Visual
 Sensory Mental
 Sphincter Autre

MSFC scales

Timed 25 feet-walk (test 1 / test 2)
 9-HPT, dominant hand (test 1 / test 2)
 9-HPT, other hand (test 1 / test 2)
 PASAT (3 sec / 2 sec)

Symptoms & Signs

<input type="checkbox"/> Motor	<input type="checkbox"/> Walking difficulties <input type="checkbox"/> Lower extremity motor <input type="checkbox"/> Upper extremity motor	<input type="checkbox"/> Falls <input type="checkbox"/> Spasticity	<input type="checkbox"/> Weakness <input type="checkbox"/> Clumsiness <input type="checkbox"/> Tremor
<input type="checkbox"/> Sensory		<input type="checkbox"/> Lhermitte sign <input type="checkbox"/> Pain	<input type="checkbox"/> Paresthesia <input type="checkbox"/> Dysesthesia
<input type="checkbox"/> Sphincter	<input type="checkbox"/> Bladder/bowel dysfunction <input type="checkbox"/> Sexual dysfunction		
<input type="checkbox"/> Brainstem	<input type="checkbox"/> Oculomotor	<input type="checkbox"/> Double vision <input type="checkbox"/> Oscillopsia	<input type="checkbox"/> Internuclear ophtalmoplegia <input type="checkbox"/> Ocular nerve palsy <input type="checkbox"/> Gaze paresis
	<input type="checkbox"/> Vestibular / Cochlear	<input type="checkbox"/> Vertigo <input type="checkbox"/> Hypoacusia	<input type="checkbox"/> Nystagmus
	<input type="checkbox"/> Facial motor	<input type="checkbox"/> Facial palsy <input type="checkbox"/> Hemispasm	<input type="checkbox"/> Myokymia
	<input type="checkbox"/> Facial sensory	<input type="checkbox"/> V paresthesia <input type="checkbox"/> V neuralgia	<input type="checkbox"/> V hypoesthesia <input type="checkbox"/> Atypical pain
	<input type="checkbox"/> Bulbar impairment	<input type="checkbox"/> Speech impairment	<input type="checkbox"/> Swallowing impairment
<input type="checkbox"/> Optic neuritis		<input type="checkbox"/> Loss of visual acuity <input type="checkbox"/> Ocular pain	<input type="checkbox"/> Dyschromatopsia
<input type="checkbox"/> Mental deterioration			
<input type="checkbox"/> Psychiatric symptoms		<input type="checkbox"/> Mood alteration <input type="checkbox"/> Delusions <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Depression <input type="checkbox"/> Euphoria
<input type="checkbox"/> Other	<input type="checkbox"/> Uhthoff sign <input type="checkbox"/> At heat <input type="checkbox"/> At effort <input type="checkbox"/> Paroxysmal symptoms <input type="checkbox"/> Tonic spasm <input type="checkbox"/> Other	<input type="checkbox"/> Fatigue <input type="checkbox"/> Headache <input type="checkbox"/> Horner <input type="checkbox"/> Epilepsy	<input type="checkbox"/> Amyotrophia <input type="checkbox"/> Extrapyrarnidal <input type="checkbox"/> Aphasia <input type="checkbox"/> Lobar cerebral syndromes <input type="checkbox"/> Other

Serious Adverse Event - Intercurrent Disease

Since last visit or previously: Unknown No Yes If yes, specify: PML Infection (virus, bacteria, fungus) Cancer Opportunistic infection

PARACLINICAL ASSESSMENT

MRI

Date: Day Month Year

	T1	T1/Gado	T2/PD/FLAIR(*)	Number of T2/PD/FLAIR lesions		
	Not done Negative Positive	Not done Negative Positive	Not done Negative Positive	Total	Peri-ventricular	Juxta-cortical
BRAIN	Supratentorial 			○ < 9, specify exact nb: <input style="width: 30px;" type="text"/> ○ ≥ 9 □ Confluent lesions	○ 0 ○ 1 ○ 2 ○ ≥ 3	○ 0 ○ ≥ 1
	Infratentorial 					
SPINAL CORD	Cervical 			○ 0 ○ 1 ○ ≥ 2	(*) Tick this box if FLAIR was performed: <input type="checkbox"/>	
	Thoracolumbar 					
OPTIC NERVE						

COMPARISON WITH PREVIOUS MRI

• New lesion(s): | • Overall: Unchanged, or Improved
 Worsened

MS DIAGNOSIS CRITERIA Paty Barkhof

EVOKED POTENTIALS

Date: Day Month Year

		Not done	Normal	Abnormal		Not done	Normal	Abnormal
VISUAL		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BRAINSTEM AUDITORY		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
SOMATOSENSORY	Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
MOTOR	Upper limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	Lower limbs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
		RIGHT				LEFT		

CEREBRO-SPINAL FLUID

Date: Day Month Year

White cell count Not done < 2 / mm³ ≥ 2 / mm³, exact number:

Chemistry

	CSF (mg/l)	Serum (g/l)	
Total proteins	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	
Albumin	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	
IgG	<input style="width: 100px;" type="text"/>	<input style="width: 100px;" type="text"/>	IgG index: <input style="width: 50px;" type="text"/>

Oligoclonal banding Unknown No Yes Equivocal