PATIENT NAME _____ **DATE** _____

Disease Modifying Agent:

☐ Avonex ☐ Betaseron ☐ Copaxone ☐ Rebif

☐ Novantrone ☐ Tysabri ☐ Other: _____

List of Current Medications	Dosage (mg)	Number of Tablets (one, two, three, etc.)	Number of times per day (one, two, or as needed)

(Please list additional medication on the back side of this form.)

List of problems you wish to discuss with Dr. Fox
(Prioritize the most important symptoms or problem you are experiencing)

1. _____

2. _____

3. _____