# Myasthenia Gravis Activities of Daily Living (MG-ADL)

Your generalized Myasthenia Gravis symptoms can vary from day to day. Painting a clear picture of how they affect you over time is the best way that you and your doctor can ensure that you receive the best care possible. This assessment tool allows you to measure the symptoms that most affect your daily living. Fill out this form with your doctor.

- Form should take just 10 minutes to complete
- Simply give yourself a score (from 0-3) for each activity listed and add the results
- Complete form twice per year or as instructed by your doctor

**Estimated time to complete: about 10 minutes**

<table>
<thead>
<tr>
<th>Activity</th>
<th>Score 0</th>
<th>Score 1</th>
<th>Score 2</th>
<th>Score 3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Talking</td>
<td>Normal</td>
<td>Intermittent slurring or nasal speech</td>
<td>Constant slurring or nasal speech, but can be understood</td>
<td>Difficult-to-understand speech</td>
</tr>
<tr>
<td>Chewing</td>
<td>Normal</td>
<td>Fatigue with solid food</td>
<td>Fatigue with soft food</td>
<td>Gastric tube</td>
</tr>
<tr>
<td>Swallowing</td>
<td>Normal</td>
<td>Rare episode of choking</td>
<td>Frequent choking necessitating changes in diet</td>
<td>Gastric tube</td>
</tr>
<tr>
<td>Breathing</td>
<td>Normal</td>
<td>Shortness of breath with exertion</td>
<td>Shortness of breath at rest</td>
<td>Ventilator dependence</td>
</tr>
<tr>
<td>Impairment of ability to brush teeth or comb hair</td>
<td>None</td>
<td>Extra effort, but no rest periods needed</td>
<td>Rest periods needed</td>
<td>Cannot do one of these functions</td>
</tr>
<tr>
<td>Impairment of ability to arise from a chair</td>
<td>None</td>
<td>Mild, sometimes uses arms</td>
<td>Moderate, always uses arms</td>
<td>Severe, requires assistance</td>
</tr>
<tr>
<td>Double vision</td>
<td>None</td>
<td>Occurs, but not daily</td>
<td>Daily, but not constant</td>
<td>Constant</td>
</tr>
<tr>
<td>Eyelid droop</td>
<td>None</td>
<td>Occurs, but not daily</td>
<td>Daily, but not constant</td>
<td>Constant</td>
</tr>
</tbody>
</table>

Patient name: ____________________________

Date of birth: _____ / _____ / ______  Date: _____ / _____ / ______

Medical record number: __________________

Time of day completed: __________________

Total score: ______ of 24

MG-ADL assessment adapted from www.myasthenia.org/HealthProfessionals/EducationalMaterials.aspx. The information on this page is intended as educational information for patients and their healthcare providers. It does not replace a healthcare provider’s independent medical judgment or clinical diagnosis.