

Health Questionnaire

Nerve Conduction Studies/Electromyography

**DO NOT APPLY ANY LOTION TO YOUR SKIN FOR AT LEAST 72 HOURS
PRIOR TO YOUR TEST (All extremities)**

Name: _____ Date: _____ DOB: _____

Chief Complaint: _____

Brief History of Problem: _____

Are there specific areas of numbness/weakness _____

Duration of symptoms _____

Any injury? _____

Any activity or position that worsens symptoms? _____

Past Medical History: (Please check if applicable)

___ High Blood Pressure ___ Diabetes ___ Stroke ___ Heart Problems ___ Lung Problems

___ Glaucoma ___ Cancer ___ Anemia ___ Liver disease ___ Blood Clots

___ Epilepsy ___ Gastrointestinal ___ Gynecological Problems

Other: _____

Surgical History: _____

Habits:

Alcohol ___ # drinks/week Cigarettes ___ # cig/day x ___ # years ___ year quit

Other tobacco usage: _____ Current frequency: _____

Caffeine ___ # cups/day Recreational Drugs: _____

Family History:

___ Migraine ___ High Blood Pressure ___ Cancer

___ Epilepsy ___ Diabetes ___ Anemia

___ Cerebral Aneurysm ___ Stroke ___ Liver Disease

___ Multiple Sclerosis ___ Heart Problems ___ Blood Clots

___ Parkinsons ___ Lung Problems ___ Osteoporosis

___ Alzheimer/Dementia ___ Glaucoma

Other: _____

Allergies: _____

Name: _____ Date: _____ DOB: _____

Current Medications:

Medication	Dosage	Action

Review of Current/Recent Symptoms: (check all that are applicable)

General: ___ Fever ___ Chills ___ Weight Loss ___ Weakness

Skin: ___ Rash ___ Itching

Hematopoietic: ___ Bruising ___ Bleeding ___ Anemia

HEENT: ___ Vision changes ___ Double vision ___ Glaucoma ___ Hearing problems
 ___ Vertigo

Respiratory: ___ Cough ___ Coughing Blood ___ Shortness of Breath ___ Infections

Cardiovascular: ___ Chest Pain ___ Murmurs ___ Pain in legs with walking ___ Swelling in the legs

Gastro-Intestinal: ___ Constipation ___ Diarrhea ___ Bleeding ___ Hemorrhoids ___ Indigestion
 ___ Hepatitis

Genito-Urinary: ___ Burning ___ Bleeding leaking (incontinence) ___ Flank pain ___ Loss of erections

Muscle-skeletal: ___ Joint Pain ___ Weakness ___ Back pain ___ Cramps

Neurologic: ___ Headache ___ Dizziness ___ Seizures ___ Blackouts ___ Depression
 ___ Sleeping problems

Other: _____

Other Comments: _____

Signature

Date