

# 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)**

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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