Electrodiagnostic Testing

NAME:_____ **DATE:**_____

DATE OF BIRTH: _____ **AGE:** _____ **SEX: M F**

REFERRING PHYSICIAN: _____

WHEN DID YOUR SYMPTOMS BEGIN? _____

IS THIS WORK RELATED? _____

DESCRIBE YOURCOMPLAINTS:_____

_____

_____

_____

_____

SYMPTOMS ARE WORSENED WITH: _____

_____

SYMPTOMS ARE IMPROVED WITH: ☐ **Rest/Bed** ☐ **Lying down** ☐ **Walking/Standing** ☐ **Time of day**

☐ **Being around people** ☐ **Sexual activity** ☐ **Physical activity** ☐ **Drugs** ☐ **Exercise** ☐ **Other** _____

RECENT PRIOR TESTING:

TEST	WHEN	WHERE
X-RAYS		
CT SCAN/ MRI		
EMG/NCV		
OTHER		

PAST MEDICAL HISTORY:

❑ **Diabetes** ❑ **High blood pressure** ❑ **Hepatitis** ❑ **Thyroid Disease** ❑ **Ulcer**
❑ **Cancer** **If so what kind?**_____ ❑ **Heart Disease** ❑ **Tuberculosis** ❑ **Lung Disease**
❑ **Kidney Disease** ❑ **Arthritis** ❑ **Depression** ❑ **Other Illnesses** _____

Prior Hospitalization:_____

Surgical History (Procedure and Year):_____

_____

TURN PAGE OVER AND COMPLETE OTHER SIDE

FAMILY HISTORY:

❑ **Diabetes** ❑ **High blood pressure** ❑ **Cancer** **If so what kind** _____ ❑ **Heart Disease**
❑ **Depression** ❑ **Disability** ❑ **Chronic pain** ❑ **Stroke** ❑ **Alcoholism** ❑ **Migraine**
❑ **Other** _____

SOCIAL HISTORY: Occupation_____ Currently Working? YES NO

Smoke: YES NO How much? _____ How Long? _____

Alcohol: YES NO How much?_____ How Long?_____

Marital Status ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Separated** ❑ **Widowed** **How long?** _____

MEDICATIONS:_____

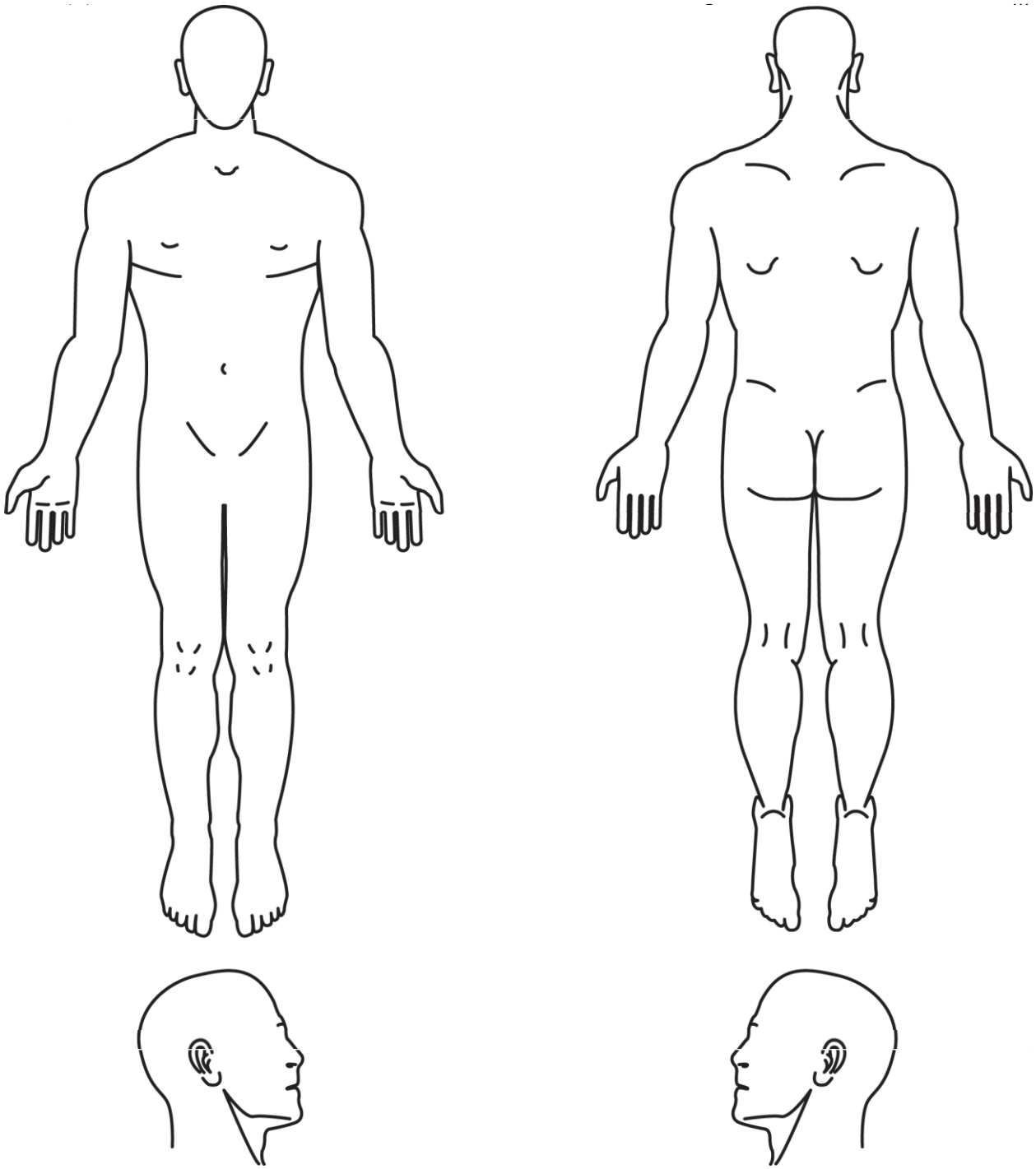
_____

ALLERGIES: _____

YOU MAY USE THE AREA BELOW FOR ANY ADDITIONAL COMMENTS OR INFORMATION THAT YOU FEEL IS IMPORTANT REGARDING YOUR CURRENT MEDICAL CONDITION.

Complete the following diagram drawing the symbols below to show where you have your typical pain

Ache ➢➢ Numbness ■ Pins and Needles ○ Burning Stabbing ///



What is your average pain? Or give a range of your level of pain.
"0" indicates NO PAIN and "10" indicates pain so severe it would cause you to faint or lose consciousness

0 1 2 3 4 5 6 7 8 9 10

Patient Name:_____ Date of Birth:_____

Please review the following list of medical problems and mark any that apply to you *now* or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

Constitutional

- ☐ Recent weight gain: ____ lbs
- ☐ Recent weight loss: ____ lbs
- ☐ Fever or soaking sweats at night
- ☐ Fatigue
- ☐ Weakness/numbness of arms/legs
- ☐ Headaches ≥1-2 times per week
- ☐ Difficulty walking
- ☐ Loss of consciousness/convulsions

Eyes

- ☐ Vision problems not corrected by glasses
- ☐ Glaucoma
- ☐ Eye lens implant
- ☐ Eye prosthesis
- ☐ Contact lenses

Ears, Nose, Throat

- ☐ Chronic stuffy nose or nasal polyps
- ☐ Frequent nosebleeds
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Ear infections
- ☐ Hearing aid
- ☐ Chronic sore throat or tonsillitis
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Dentures or partial plates
- ☐ Capped teeth
- ☐ Loose teeth
- ☐ Orthodontic braces

Cardiovascular

- ☐ Heart murmur
- ☐ Prolapsed mitral valve
- ☐ Heart pacemaker
- ☐ Irregular heartbeat
- ☐ Palpitations or rapid pulse
- ☐ Fainting spells
- ☐ Chest pain or angina on exertion
- ☐ Chest pain or angina at night
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath lying flat
- ☐ Shortness of breath at night
- ☐ Blood clots or pulmonary embolism
- ☐ High blood pressure
- ☐ Low blood pressure

Respiratory

- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Chronic cough
- ☐ Change in amount of phlegm
- ☐ Change in color of phlegm
- ☐ Coughing up blood
- ☐ Collapsed lung
- ☐ Tuberculosis exposure
- ☐ Blueness of your fingernails

Gastrointestinal

- ☐ Ulcers
- ☐ Hiatal hernia or frequent heartburn
- ☐ Ulcerative colitis
- ☐ Diverticulitis
- ☐ Colostomy or other 'ostomy'
- ☐ Hepatitis or yellow jaundice
- ☐ Liver cirrhosis
- ☐ Gallbladder problems
- ☐ Vomiting blood
- ☐ Black, tarry bowel movements
- ☐ Blood in bowel movements
- ☐ Change in bowel habits

Genitourinary

- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Prostate problems
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Do you lose your urine at times

Musculoskeletal

- ☐ Fractures or broken bones
- ☐ Arthritis
- ☐ Difficulty opening mouth wide
- ☐ Scoliosis
- ☐ Spinal column deformity

Integumentary/Dermatologic

- ☐ Skin rash or sores
- ☐ Itching
- ☐ Color change, pigmentation, nodules
- ☐ Pressure ulcers

Neurologic

- ☐ Seizures or convulsions
- ☐ Epilepsy
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple Sclerosis
- ☐ Nerve Injury or Numbness

Psychiatric

- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Mental disorder

Endocrine

- ☐ Diabetes
- ☐ Insulin use
- ☐ Low blood sugar or hypoglycemia
- ☐ Thyroid problems
- ☐ Steroid use

Allergic/Immunologic

- ☐ Herpes exposure
- ☐ AIDS exposure
- ☐ Street drug use

Hematologic

- ☐ Abnormal bleeding problems
- ☐ Anemia or low blood count
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell anemia

Lymphatic

- ☐ Swollen glands or masses in neck, axillae, groin
- ☐ Lymphedema

Others

- ☐ Sexual problems
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Malignant hyperthermia
- ☐ Bad reaction to local anesthetic
- ☐ Down syndrome
- ☐ Cancer or tumor
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Recent acute illness
- ☐ Recent hospitalization
- ☐ Recent surgical operation

Use the back of this page to list any problems not already covered that you consider important

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For women only:

Are you pregnant? ☐ Yes ☐ No
Are menstrual periods normal? ☐ Yes ☐ No
☐ Any vaginal discharge
☐ Bleeding between periods
☐ Bleeding after menopause

Number of pregnancies: _____
Number of deliveries: _____
Date of last menstrual period: _____
Approx date of last pap smear: _____

I have carefully reviewed this checklist and completed it to the best of my knowledge. Date: _____

Signature of Patient, Parent, or Guardian ***Relationship to patient, (if not self)***

Patient Name:_____ Date of Birth:_____