EMG/NCV Patient Questionnaire

Patient Name:__________________________ **Age:** _______ **EMG Date:**______________

Occupation: _________________________ **Height:** _________ **Weight:**_________

Have you had this test before? ______________________ **What year:**_________

Reason for today's visit: ____

Do you have the following symptoms:

____ **Pain,** Where ______________________________________

___ **Weakness,** Where____________________________________

____**Numbness,** Where___________________________________

____**Tingling,** Where_____________________________________

____**Burning,** Where_____________________________________

____**Muscle Cramps** and **Twitching,** Where______________________________

Have you had any falls in the last 6-12 months, Yes_____No ______________

Do you have any allergy to medications if so,

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Reaction: ____

Do you have any allergy to IV Dyes if so, ______________________________

Reaction: _____________________

Are you currently on a blood thinner? If yes, ______________________________

Do you have a pacemaker____ Pain Stimulator________ Currently in Dialysis_______

<u>Do you have any of the following:</u>

Diabetes Mellitus: Type I ____ Type II____

Thyroid Disease: Hyper____ Hypo____ Hashimotos_____

HIV____ Hepatitis_____

History of cancer yes, what type__________________________ **Year:** _________

Other Conditions _______________________________________

Medications currently taking: ____

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Family History: Parents Living: Mother: Yes___ No___ **Age:**___ Dad: Yes_____ No _______

<u>Age:</u>______

Family History of Neuropathy or Musculay disorders: Yes_____

Condition:_____________________ No_____

Have you had any

surgeries?____

Any recent imaging: X-ray's, MRI'S, CT Scans or other testing? ______________________

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Do you drink alcohol? Yes _______ No____________ **Do you smoke:** Yes ____No ____