ELECTRODIAGNOSTIC PATIENT FORM

Date: ____________________

Name: ______________________________ Birthdate: ______________ Age: ____________

Date of injury: ____________ Claim # __________ Claims Manager (if work-related) ____________________

Reason for referral: ____

Right or left handed (circle one) Date of onset ______________

Referring physician name and address: ____

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Have you had a prior EMG/nerve conduction study? ____ Yes ____ No

If so, when? ____________________ Where? ______________________________________

What was studied? ____

What were the findings? ____

Do you have pain to your? ____ Neck ____ Mid-back ____ Low back

____ Right arm ____ Left arm ____ Ribs

____ Right leg ____ Left leg

Is the pain? (circle) Sharp Stabbing Electrical Burning Aching Throbbing

Tight Pressure Other: ____________________________________

Is the pain constant? ____ Yes ____ No

How severe is the pain? (Scale of 0 – 10; 0 is no pain and 10 is severe pain) ____________________

Do you have numbness? (asleep, dead or pins and needle feeling) ____ Yes ____ No

If yes, where is it numb?____

Do you have weakness? (muscle getting weak or not as strong) ____ Yes ____ No

If so, where is it weak? ____

Do your muscles twitch? ____ Yes ____ No

If yes, where do they twitch? ____

Do you have bowel or bladder control issues? ____ Yes ____ No

If yes, explain: ____

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Have you had surgery to your: (circle all that apply)

Neck Mid-back Low back Arms Shoulder Elbow Wrist
Hand Hips Knees Feet

If so, explain:

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Do you have a bleeding disorder? ____ Yes ____ No

Do you take Coumadin/Warfarin? ____ Yes ____ No

If so, what was your most recent INR level? ____

Are you a diabetic? ____ Yes ____ No Number of years with diagnosis ____________

If yes, are you insulin-dependent? ____ Yes ____ No

Do you have thyroid disease? ____ Yes ____ No

Do you have a pacemaker? ____ Yes ____ No

SYSTEMS REVIEW: (Please circle those that apply):

Constitutional: Chills, fatigue, fever, unexpected weight change
Head, Ears, Nose and Throat: Hearing loss, tinnitus (ringing in ears), drooling, trouble swallowing
Eyes: Visual disturbance
Respiratory: Apnea, cough, shortness of breath
Cardiovascular: Chest pain, palpations
Gastrointestinal: Blood in stool, constipation, diarrhea, nausea, vomiting, bowel incontinence
Gastrourinary: Difficulty urinating, frequency, urgency, bladder incontinence
Musculoskeletal: Arthralgias, back pain, gait problems, joint swelling, myalgias
Skin: Rash, wound
Neurological: Dizziness, headaches, light-headedness, numbness, seizures, speech difficulty, weakness
Hematologic: Adenopathy, bruises/bleeds easily
Psychiatric Agitation, confusion, dysphoric mood, nervous/anxious, sleep disturbance, suicidal ideas

MEDICAL HISTORY: (Circle items that apply to you)

Diabetes	Arthritis	Heart disease	Brain injury
High blood pressure	Chronic pain	High cholesterol	Fibromyalgia
History cancer	MS	Kidney disease	Muscular dystrophy
Low thyroid	Spinal cord injury	Lung disease	Spine (neck or back) pain
Stroke			

All other medical history (including surgeries) PLEASE BE COMPLETE AND LIST ALL MEDICAL HISTORY:

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Physician notes:

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