PROVIDENCE
St. Mary
Neuroscience Institute

NCS/EMG Consult

Name: ______________________ **Today's Date:** ______________________

Date of Birth: ______________________ **Age:** __________ Height: _______ Weight: _______

PCP: ______________________ **Who Referred:** ______________________

When did you first start experiencing numbness and/or tingling?______________________
Are you currently taking any blood thinning medication such as Coumadin or Heparin?______________________
Do you have an implanted electronic device such as a pacemaker?______________________
Do you have a history of diabetes?______________________
If YES, when were you diagnosed?______________________
Do you have a history of thyroid disease?______________________
Do you have a history of rheumatoid arthritis?______________________
Do you have a history of exposure to chemicals?______________________
Do you have a history of cancer treatment, radiation/ chemotherapy?______________________
Do you have a history of frequent alcohol consumption? ______________________
Have you had a nerve conduction study in the past? ______________________
Do your symptoms wake you up from sleep?______________________
Do you ever drop objects due to your weakness?______________________
Do you have neck pain?______________________
Do you have back pain?______________________

Where are you having symptoms?

□ Numbness — Where (i.e. hands or feet, what toes/fingers)? ______________________

□ Weakness — Where (i.e. hands or feet, what toes/fingers)? ______________________

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, sleep, gripping, standing, walking, sitting, lying, wrists & splints, medication, or nothing.

What worsens your symptoms (please circle all that apply): Nothing, sleeping, rest, shaking hands, sitting, standing, change of position, walking, squatting, lying down, driving, talking on the phone, gripping.

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

Quality of the pain (mark up to four):

□ Sharp	□ Shooting	□ Crushing	□ Tight Band
□ Numbing	□ Pulsating	□ Aching	
□ Tingling	□ Dull	□ Throbbing	

How severe is the pain at the location described above? ☐ No Pain ☐ Mild ☐ Moderate ☐ Severe

Is the pain (check all that apply)?

☐ Rare ☐ Infrequent ☐ Occasional ☐ Intermittent

☐ Daily ☐ Continuous ☐ Weekly ☐ Monthly

What treatments have you tried for <u>this</u> problem?

☐ Physical Therapy ☐ TENS units ☐ Narcotic Medications ☐ Muscle Relaxers

☐ Massage ☐ Traction ☐ Anti-inflammatories ☐ Orthotics

☐ Chiropractor ☐ Surgery ☐ Steroid injections ☐ Braces

☐ Other: ____________________________________

Previous physicians seen for <u>this</u> problem?

Physician	Specialty	City	Treatment

PAST MEDICAL HISTORY: Check all that apply ☐ None Apply

☐ Abnormal heartbeat ☐ Cirrhosis ☐ High blood pressure Neuropathy: ☐ Hands ☐ Feet

☐ ADHD ☐ Depression ☐ High cholesterol ☐ Poor circulation

☐ Anemia ☐ Down syndrome ☐ HIV/AIDS ☐ Seizure

☐ Anxiety ☐ Emphysema ☐ Kidney failure ☐ Spina bifida

☐ Asthma ☐ Gastric reflux ☐ Kidney stones ☐ Stomach ulcers

☐ Bleeding disorder ☐ Gout ☐ Migraine ☐ Stroke

☐ Blood clots in leg ☐ Heart attack ☐ Multiple Sclerosis (MS) ☐ Thyroid

☐ Blood clots in lung ☐ Heart failure ☐ Neurofibromatosis ☐ Tuberculosis

☐ Cerebral palsy ☐ Hepatitis B or C ☐ Osteoporosis ☐ Fibromyalgia

☐ Osteoarthritis ☐ Rheumatoid arthritis ☐ Other Rheumatological Disease

☐ Other : ____

____

PAST SURGICAL HISTORY: □ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia: ____

SOCIAL HISTORY: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation:____

Education:____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ No □ **Yes, how many?** _________________

Do you live alone? □ Yes □ No **If no, who lives with you?** ____

Are you currently smoking? □ Yes □ No **If yes, how many pack/day?** _____ **And for how many years?** _____

Have you previously quit smoking? If so, when did you quit? _____ **How many years did you smoke?** _____

How many packs a day did you previously smoke? _____ **Other forms of tobacco used?** _______________________

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week) □ Alcoholic □ Recovering alcoholic

Illegal drug use: □ Never □ In the past □ Currently □ Types of drugs? ___________________________________

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	

Other: ____

____

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown ☐

Adopted ☐

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

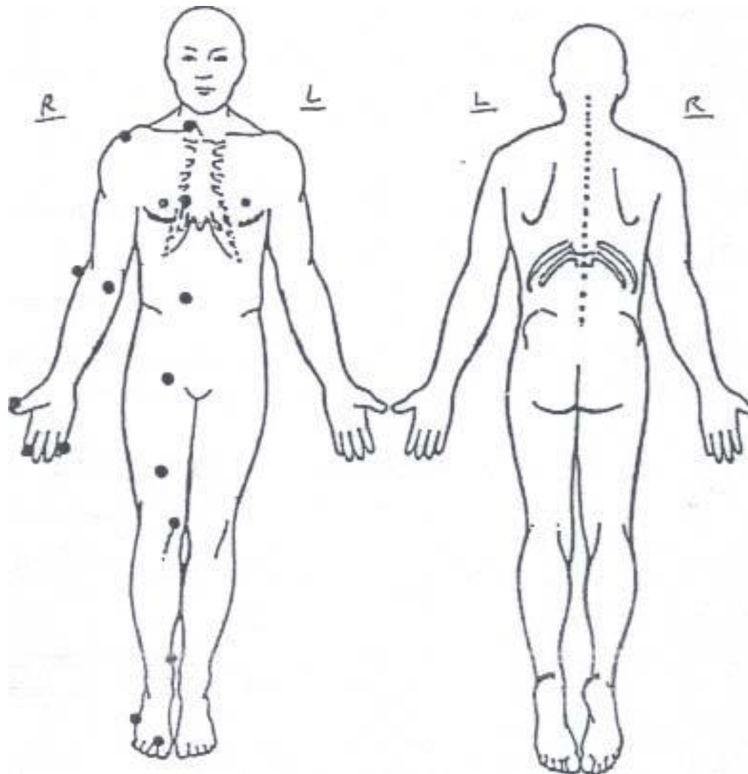
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient's signature: ________________________________

Provider signature: ________________________________

Date: ____

Date: ____