EMG/NCV Patient Questionnaire

Patient Name:_____ Age:__ EMG Date:_____

Patient Occupation:_____Height:_____ Weight:_____
Did you have this test before: Y or N If so, when was it done?_____

Why are you having this test?_____
Describe your
symptoms_____
How long have you had this problem?_____

Do you have any of the following:
__Weakness. If so, Where?_____
__Numbness. If so, Where?_____
__Tingling. If so, Where?_____
__Burning. If so, Where?_____
__Pain. If so, Where?_____
__Muscle Cramps. If so, Where?_____
__Muscle Twitching. If so, Where?_____

Do you have any of the following:
__Diabetes Mellitus
__Thyroid Problems
__HIV or hepatitis
__Pacemaker
__History of cancer
What type of cancer and when?_____
_____
__Other medical conditions?_____
_____

Medications you take:_____
_____
_____
_____
Pharmacy Name and Number:___
_____
Do you take coumadin? Y or N
If so, do you know your INR
value:_____

__Family history of neuropathy or musculay disorders. If so describe:___
_____
Have you had any surgery?___If so, please describe:_____
Have you had any recent imaging such as X-ray, MRI, CT, etc?____
If so, when and what part?_____
Do you currently smoke or have a history of? Y or N If so, how long____
Do you currently drink alcohol or have a history of? Y or N? How often___

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CHRISTIANA SPINE CENTER, P.A.

4735 Ogletown Stanton Road
Medical Arts Pavilion 2, Suite 3302
Newark, DE 19713

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

EFFECTIVE DATE: July 1, 2009
REVISED: December 2017

NOTICE OF PRIVACY PRACTICE/PATIENT RIGHTS

I have had the opportunity to receive and review Christiana Spine Center's Notice of Privacy Practices.

Signed: _____ **Date:** _____

Witness: _____

I have read and understand section C of this document "Your Rights Regarding Your Medical Information". In addition to section C of this document, this consent allows the practice to disclose information regarding me to the following:

Print Name	**Relationship to Patient**
_____	_____
_____	_____
_____	_____
_____	_____