EMG/NCV Patient Questionnaire

Occupation:	tient Name:	Age:		MG Date:	
Have you had this test before? What year:			Weight:		
Reason for today's visit: Do you have the following symptoms: Pain, Where Weakness, 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 the following symptoms:	ason for today's visit:				
	you have the following symptoms:	•			
	Pain, Where				
Tingling, Where	_ Weakness, Where				
Burning, Where	Numbness, Where				
Muscle Cramps and Twitching, Where	Tingling, Where				
Have you had any falls in the last 6-12 months, YesNoNoNo	Burning, Where				
Reaction: Do you have any allergy to IV Dyes if so, 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_ Do you have any of the following: 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: Family History: Parents Living: Mother: Yes No Age: Dad: Yes NAge: Family History of Neuropathy or Musculay disorders: Yes Condition: No Have you had any					
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Condition: No Have you had any	-			· <u>-</u>	
Condition: No Have you had any	mily History of Neuropathy or Musculay	disorders:	Yes	_	
Have you had any					
	ve you had any				
Any recent imaging: X-ray's, MRI'S, CT Scans or other testing?					
Do vou drink alcohol? Yes No Do vou smoke: Yes				1	