CLINICAL ELECTROPHYSIOLOGY
Patient History

Name: _____

Last First MI

Age: _____ **Sex:** Male ☐ Female ☐

Language: ☐ English Understood
☐ Interpreter Needed
☐ Language Spoken most often:

Hand Dominance:
☐ Right Handed
☐ Left Handed

GENERAL HEALTH STATUS
Please rate your health:
☐ Excellent ☐ Good ☐ Fair ☐ Poor

SOCIAL & HEALTH HABITS
a) Do you Smoke? ☐ Yes ☐ No
# of packs/day _____
# of cigars/pipes a day_____
Have you smoked in the past? ☐ Yes ☐ No
Year Quit_____

b) Alcohol
days/week you drink on average_____
of drinks you have on average day_____

Family History (and relation to you):
☐ Heart Disease_____
☐ Hypertension_____
☐ Stroke_____
☐ Diabetes_____
☐ Cancer_____
☐ Psychological_____
☐ Arthritis _____
☐ Osteoporosis_____

☐ Other_____

Other Clinical Test in Past Year

☐ MRI ☐ CT Scan ☐ NCV/EMG
☐ EKG ☐ Bone Scan ☐ Biopsy
☐ X-ray ☐ Myelogram ☐ Blood Test
☐ Stress Test ☐ Urine Test
☐ Other_____

Medications
Prescription Meds:
_____
_____
_____

Over the counter Meds including herbal medications
_____
_____
_____

Medical/Surgical History

Check if you have or have had:

- ☐ Arthritis
- ☐ Fractures
- ☐ Osteoporosis
- ☐ Blood Disorders
- ☐ Circulatory Problems
- ☐ Heart Problems
- ☐ High Blood Pressure
- ☐ Lung Problems
- ☐ Stroke
- ☐ Diabetes
- ☐ Hypoglycemia
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Parkinson's Disease
- ☐ Seizures
- ☐ Growth Problems
- ☐ Allergies
- ☐ Thyroid Problems
- ☐ Cancer
- ☐ Infectious Diseases
- ☐ Kidney Problems
- ☐ Ulcers
- ☐ Skin Diseases
- ☐ Depression
- ☐ Muscular Dystrophy
- ☐ Other

Have you ever had surgery? ☐ No ☐ Yes

1) Date: _____ Surgery _____
2) Date: _____ Surgery _____
3) Date: _____ Surgery _____
4) Date: _____ Surgery _____

Within the past year, have you had these symptoms?

- ☐ Chest Pain
- ☐ Heart Palpitations
- ☐ Shortness of breath
- ☐ Dizziness/Blackouts
- ☐ Loss of Balance
- ☐ Generalized Weakness
- ☐ Difficulty Sleeping
- ☐ Nausea/Vomiting
- ☐ Weight loss/gain
- ☐ Coordination problems
- ☐ Pain at night
- ☐ Difficulty Swallowing
- ☐ Bowel Problems
- ☐ Urinary Problems
- ☐ Headaches
- ☐ Vision Problems
- ☐ Hearing Problems
- ☐ Cough/hoarseness
- ☐ Loss of appetite
- ☐ Fever chills/sweats
- ☐ Joint pain or swelling

Other Medical Care

Are you seeing anyone else for your problem?

_____

Functional Status

- Difficulty walking stairs ☐
- Difficulty getting in/out of bed ☐
- Difficulty getting up from a chair ☐
- Difficulty walking on ground level ☐
- Difficulty walking up or down inclines ☐
- Difficulty bathing or dressing ☐
- Difficulty with household chores ☐
- Difficulty driving ☐
- Difficulty with work activities ☐

Additional Comments:

_____
_____
_____
_____

Current Condition/Chief Complaint

Describe the problems for which you see EMG/NCV testing: _____
_____
_____
_____
_____

Date of onset _____