

UPPER OR LOWER EXTREMITY EMG PATIENT INFORMATION FORM

PLEASE COMPLETE THIS FORM AND BRING IT WITH YOU TO YOUR APPOINTMENT. SOME QUESTIONS MAY NOT APPLY TO YOUR SITUATION.

NAME: _____

AGE: _____ DOMINANT HAND: _____ RIGHT _____ LEFT

LOCATION OF YOUR CURRENT PAIN/WEAKNESS: _____

DO YOUR SYMPTOMS AFFECT BOTH SIDES? _____

WHEN AND HOW DID THIS PAIN BEGIN? _____

HOW LONG HAVE YOUR SYMPTOMS BEEN AT THEIR CURRENT LEVEL OF INTENSITY? _____

DO YOU HAVE NUMBNESS? _____ WEAKNESS? _____ BURNING? _____ TINGLING? _____

IF YOUR HANDS ARE AFFECTED, DO YOU USE WRIST SPLINTS? _____ HAVE YOU HAD SURGERY ON YOUR AFFECTED HAND(S)? _____

CHECK ALL THAT MAKE THE PAIN **WORSE**:

- ____ 1. AT NIGHT
- ____ 2. MOVEMENT OF _____ NECK _____ SHOULDER
- ____ 3. MOVEMENT OF _____ WRIST _____ HAND _____ ARM
- ____ 4. GRASPING
- ____ 5. POSTURES USED WHEN _____ DRIVING _____ READING
- ____ 6. MOVEMENT OF TRUNK
- ____ 7. STANDING
- ____ 8. WALKING
- ____ 9. TWISTING/BENDING

HAVE YOU EVER HAD AN EMG TEST BEFORE? YES/NO IF SO, WHO PERFORMED THE TEST?

HAVE X-RAYS OR OTHER TESTS BEEN PERFORMED FOR THIS CONDITION? _____ **IF SO, PLEASE BRING RESULTS WITH YOU.**

WHEN IS YOUR NEXT APPOINTMENT WITH THE DOCTOR WHO REFERRED YOU FOR THIS TEST?

CHECK ANY MAJOR ILLNESSES THAT APPLY:

- ____ 1. HIGH BLOOD PRESSURE
- ____ 2. HEART DISEASE
- ____ 3. DIABETES: WHAT TYPE: INSULIN _____ DIET/MEDICATION CONTROLLED _____
- ____ 4. THYROID CONDITIONS
- ____ 5. ELEVATED CHOLESTEROL
- ____ 6. CANCER TYPE _____ RADIATION: YES/NO CHEMOTHERAPY: YES/NO
- ____ 7. HIV/HEPATITIS
- ____ 8. RHEUMATOID ARTHRITIS _____ LUPUS _____ FIBROMYALGIA _____
- ____ 9. OTHER/DESCRIBE _____

LIST ANY MAJOR SURGERIES: _____

DO YOU HAVE A FAMILY HISTORY OF ANY NEUROLOGIC DISEASE? IF SO, DESCRIBE _____

MEDICATION OR LATEX ALLERGIES? _____

IS THIS A WORKERS COMP INJURY? _____

IF SO, DID THIS REQUIRE TIME OFF WORK/HOW LONG? _____

THIS WORKSHEET **WILL NOT** BECOME A PART OF YOUR PERMANENT MEDICAL RECORD.