UT Erlanger Neuromuscular Medicine

Electrodiagnostic Laboratory
Patient Questionnaire

Complete the following (please print):

Name: _____ Date of Birth: ____ / ____ / ____
Last First MI Month Day Year

Height: _____' _____" Weight: _____ lbs
Feet Inches Pounds

Hand dominance (i.e. which hand to you write with)? ☐ Right ☐ Left

Please list the symptoms that led your provider to order these tests (e.g. pain, numbness, tingling, weakness). To help us better understand your symptoms, please complete the attached ***Symptom Chart*** if your symptoms include pain, tingling, or loss of feeling.

_____
_____
_____
_____
_____
_____
_____

How long have you been experiencing these symptoms for?

_____
_____

What medical conditions have you been diagnosed with?

_____ _____
_____ _____
_____ _____
_____ _____

Are you diabetic? ☐ Yes ☐ No

Do you have any chronic infections? ☐ Yes ☐ No

_____

What surgical procedures have you undergone?

_____ _____
_____ _____

Have you had any surgery that affects your lymphatic system? ☐ Yes ☐ No
(e.g. mastectomy) _____

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Do you have an implanted electric device? ☐ Yes ☐ No
(e.g. pacemaker, spinal stimulator)_____

Have you had any surgery on your neck, back, or nerves? ☐ Yes ☐ No

_____

Have you had spinal injections for the treatment of back/neck pain? ☐ Yes ☐ No

_____

Please list your current prescription medications.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Are you currently taking blood thinners? ☐ Yes ☐ No
*(e.g. Coumadin, Pradaxa, Eliquis, Heparin, Lovenox)*_____

Are you currently taking blood pressure medication? ☐ Yes ☐ No

Have you ever received botulinum toxin? ☐ Yes ☐ No

Are you allergic to any medications or latex/tape? ☐ Yes ☐ No
*(if so, please list)*_____

Are you aware of anyone in your family (blood relative) that has been diagnosed with a disorder of the nerves or muscles?

☐ Yes ☐ No

_____

_____

Do you currently use tobacco products? ☐ Yes ☐ No

Do you consume alcoholic beverages on a daily basis? ☐ Yes ☐ No

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While being evaluated for your symptoms, have any of the following tests been performed?

☐ Neuroimaging (e.g. MRI, CT scans)

_____

_____

☐ Laboratory evaluation

_____

_____

☐ Electrodiagnostic testing (EMG / Nerve Conduction Testing)

_____

_____

Patient Signature: _____ Date: ____ / ____ / ____

*If minor, Parent or Legal Guardian Signature:*_____

EMG Staff: Reviewed & signed by: _____