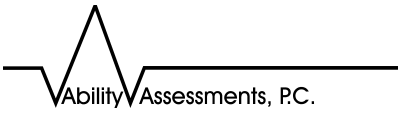

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EMG PATIENT FORM

Name_____ Date_____

Address_____ Phone_____
Street City Zip

Date of Birth_____ Social Security #_____ Height_____

Dominant Hand: R or L (circle one)

Medical History:

Do you have Diabetes? Yes / No (circle one)

Do you have Carpal Tunnel Syndrome? Yes / No (circle one)

How much alcohol do you drink? (Choose one)
_____ Never
_____ Once a day
_____ Once a week
_____ Once a month
_____ Once a year
_____ Quit. Used to drink.

Have you had this test (EMG) before? Yes / No (circle one)
If yes, where and when?_____

Have you had any surgeries? Yes / No (circle one)
If yes, list them_____
_____

What are your current symptoms?

Do you have pain? Yes / No (circle one)
If yes, where_____
How long have you had this pain?_____

Do you have numbness? Yes / No (circle one)
If yes, where_____
How long have you had this numbness?_____

Do you have weakness? Yes/No (circle one)
If yes, where_____
How long have you had this weakness?_____

Please list any doctors that you are currently seeing in relation to these problems:
_____
_____