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EMG QUESTIONNAIRE

DATE:_____________

NAME:____
(LAST) (FIRST) (MI)

PRIMARY PHYSICIAN:____

PROBLEM FOR WHICH YOU HAVING TEST DONE TODAY:

____
____
____

HOW LONG HAVE YOU HAD THIS PROBLEM: ___________________________________

DO YOU HAVE ANY SIMILAR SYMPTOMS IN ANY OF THE OTHER EXTREMITIES?
(UPPER OR LOWER) ____

DO YOU HAVE ANY: NECK PAIN:__________ SHOULDER PAIN:_________

ELBOW PAIN:__________ WRIST PAIN:__________ HIP PAIN:___________

KNEE PAIN:___________ ANKLE PAIN:__________

ARE YOUR SYMPTOMS WORSE DURING THE DAY_______________OR NIGHT__________

IS THERE ANY ASSOCIATED WEAKNESS? YES__________ NO______________

ANY HISTORY OF INJURY TO THE AFFECTED AREA? ______________________________

PAST MEDICAL PROBLEMS

	YES	NO
ARE YOU DIABETIC	____	____
HAVE CHRONIC KIDNEY PROBLEMS?	____	____
DO YOU HAVE THYROID PROBLEMS?	____	____
ANY OTHER MAJOR MEDICAL ILLNESSES?	____	____

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DO YOU SMOKE?	**YES______**	**NO_____**
HISTORY OF HEAVY ALCOHOL USE?	**YES ____**	**NO____**
EXPOSURE TO CHEMICALS OR TOXINS?	**YES____**	**NO____**
EXPOSURE TO MEDICATIONS FOR CANCER?	**YES____**	**NO____**

CURRENT MEDICATIONS: (DOSES NOT NECESSARY)

NAME OF DRUG:	**REASON FOR TAKING MEDICATION:**
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________
______________________________	____________________________________

DOES ANY ELSE IN YOUR FAMILY HAVE SIMILAR SYMPTOMS OR PROBLEMS?

PLEASE READ THE INFORMATION SHEET PROVIDED TO YOU AND ASK YOUR DOCTOR ANY QUESTIONSYOU MAY HAVE PRIOR TO STARTING THE TEST.