Providence
Medical Group

NCS/EMG Consult

Name: _____ **Today's Date:**_____

Date of Birth: _____ **Age:** _____ Height: _____ Weight: _____

PCP: _____ **Who Referred:** _____

When did your first start experiencing numbness and/or tingling? _____
Are your currently taking any blood thinning medication such as Coumadin or Heparin? _____
Do you have an implanted electronic device such as a pacemaker?_____
Do you have a history of diabetes? _____
If YES, when were you diagnosed? _____
Do you have a history of thyroid disease? _____
Do you have a history of rheumatoid arthritis?_____
Do you have a history of exposure to chemicals?_____
Do you have a history of cancer treatment, radiation/ chemotherapy?_____
Do you have a history of frequent alcohol consumption? _____
Have you had a nerve conduction study in the past? _____
Do your symptoms wake you up from sleep?_____
Do you ever drop objects due to your weakness?_____
Do you have neck pain?_____
Do you have back pain?_____

Where are you having symptoms?

□ Numbness — Where (i.e. hands or feet, what toes/fingers)? _____

□ Weakness — Where (i.e. hands or feet, what toes/fingers)? _____

What makes your symptoms better (please circle all that apply): Nothing, rest, changing position, sleep, talking on the phone, all activity, gripping, standing, walking, sitting, lying, bending

What worsens your symptoms (please circle all that apply): Nothing, sleeping, rest, shaking hands, sitting, standing, change of position, standing, walking, sitting, squatting, lying down

Please circle the description which applies to your intensity of pain: Stable, unchanged, gradually worsening, rapidly worsening, gradually improving, rapidly improving, completely resolved.

How long has the problem been present? _____ Day(s), _____ Week(s), _____ Month(s), _____ Year(s)

Quality of the pain (mark up to four):
□ Sharp □ Shooting □ Crushing □ Tight Band
□ Numbing □ Pulsating □ Aching
□ Tingling □ Dull □ Throbbing

How severe is the pain at the location described above? □ No Pain □ Mild □ Moderate □ Severe

Is the pain (check all that apply)?
□ Rare □ Infrequent □ Occasional □ Intermittent
□ Daily □ Continuous □ Weekly □ Monthly

What treatments have you tried for <u>this</u> problem?

□ Physical Therapy □ TENS units □ Narcotic Medications □ Muscle Relaxers
□ Massage □ Traction □ Anti-inflammatories □ Orthotics
□ Chiropractor □ Surgery □ Steroid injections □ Braces
□ Other: _____

Previous physicians seen for <u>this</u> problem?

Physician	Specialty	City	Treatment

PAST MEDICAL HISTORY: Check all that apply □ None Apply

□ Abnormal heartbeat
□ ADHD
□ Anemia
□ Anxiety
□ Asthma
□ Bleeding disorder
□ Blood clots in leg
□ Blood clots in lung
□ Cerebral palsy
□ Osteoarthritis
□ Cirrhosis
□ Depression
□ Down syndrome
□ Emphysema
□ Gastric reflux
□ Gout
□ Heart attack
□ Heart failure
□ Hepatitis B or C
□ Rheumatoid arthritis
□High blood pressure
□High cholesterol
□ HIV/AIDS
□ Kidney failure
□ Kidney stones
□Migraine
□ Multiple Sclerosis (MS)
□ Neurofibromatosis
□ Osteoporosis
□ Other Rheumatological Disease
Neuropathy: □ Hands □ Feet
□ Poor circulation
□ Seizure
□ Spina bifida
□Stomach ulcers
□ Stroke
□ Thyroid
□ Tuberculosis
□ Fibromyalgia

□ Other : _____

PAST SURGICAL HISTORY: □ No prior surgery

Operation	Date	Surgeon/Hospital

Have you ever had general anesthesia? □ Yes □ No

If yes, have you had any problems related to this? □ Yes □ No

Explain any problems with general anesthesia: _____

SOCIAL HISTORY: Work status

□ Working □ Homemaker □ Unemployed □ Disabled □ On leave □ Retired □ Student

Occupation:_____

Education:_____

Marital status: □ Single □ Married □ Divorced □ Widowed

Children: □ No □ **Yes, how many?** _____

Do you live alone? □ Yes □ No **If no, who lives with you?** _____

Are you currently smoking? □ Yes □ No **If yes, how many pack/day? _____ And for how many years? _____**

Have you previously quit smoking? If so, when did you quit? _____ How many years did you smoke? _____

How many packs a day did you previously smoke? _____ Other forms of tobacco used? _____

Alcohol use: □ Never □ Rare □ Social □ Frequently (more than twice a week) □ Alcoholic □ Recovering alcoholic

Illegal drug use: □ Never □ In the past □ Currently □ Types of drugs? _____

Sexually active: □ Yes □ No

FAMILY HISTORY: Please fill in the illness information below with the options listed:

Alcoholism	Cancer	High blood pressure	Other Rheumatological Disease
Arthritis	Diabetes	Kidney problems	Seizure
Bleeding problems	Gout	Lung problems	Stroke
Blood clots	Heart problems	Mental Illness	

Other: _____

_____

FAMILY MEMBER	ILLNESS	AGE	IF DECEASED, AGE AT DEATH AND CAUSE
Father			
Mother			
Brother(s)			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Paternal Uncle			
Paternal Aunt			
Maternal Uncle			
Maternal Aunt			

Family History Unknown □

Adopted □

PAIN DIAGRAM

On the diagram below, please indicate where you are experiencing pain or other symptoms.

Use the following to describe your symptoms:

A = Ache

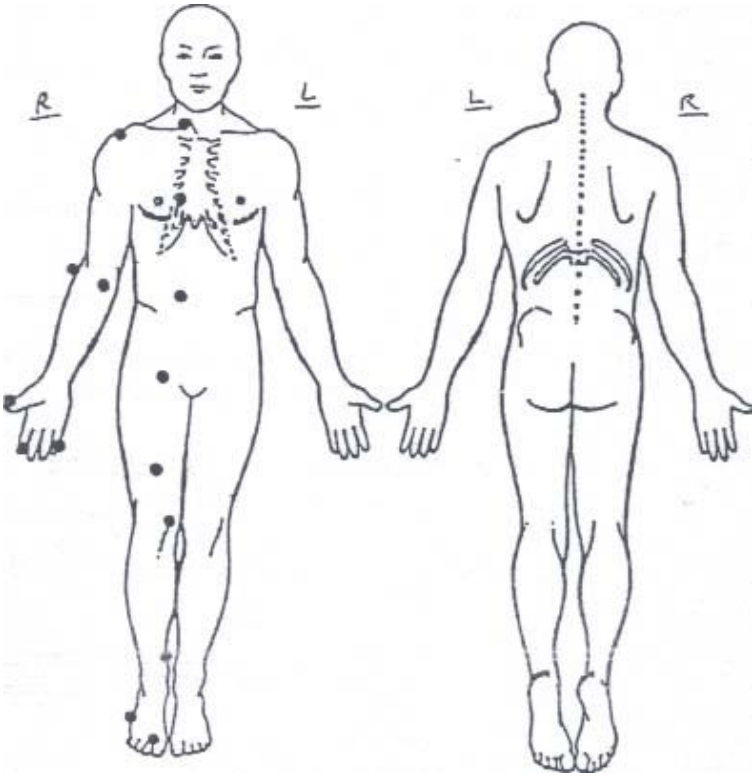
B = Burning

N = Numbness

P = Pins & Needles

S = Stabbing

O = Other



Please rate your usual level of pain on the following scale (circle one):

(no pain) 0 1 2 3 4 5 6 7 8 9 10 (worst imaginable pain)

Patient signature: _____Date:_____