MIDWEST
INTERVENTIONAL PAIN
& DIAGNOSTICS S.C.

ELECTRODIAGNOSTIC HEALTH HISTORY FORM

Today's Date: _____

Name: _____ Age: _____Dominant Hand: ☐ Right ☐ Left

Primary complaint: _____

Location of complaint: ☐ Right Hand ☐ Left Hand ☐ Right Arm ☐ Left Arm ☐ Right Leg ☐ Left Leg

Check all the words that describe your condition:

☐ Numbness	☐ Tingling	☐ Weakness	☐ Worse with standing & walking
☐ Burning	☐ Shooting	☐ Throbbing	☐ Waking up at night

Prior EMG/Nerve Test of the body region we are testing? ☐ Yes ☐ No
If yes, please indicate dates and location: _____

Prior X-ray, CT, or MRI of the body region we are testing? ☐ Yes ☐ No
If yes, please indicate date and location: _____

Medical History:

Diabetes	☐ Yes ☐ No	Bleeding disorder	☐ Yes ☐ No
Thyroid problems	☐ Yes ☐ No	Neuropathy	☐ Yes ☐ No
Pacemaker/Defibrillator	☐ Yes ☐ No	HIV or AIDS	☐ Yes ☐ No
Kidney disease	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No
History of chemo/radiation	☐ Yes ☐ No	Cancer (list below)	☐ Yes ☐ No

Surgical History:

Cervical spine (neck) surgery	☐ Yes ☐ No	Prior carpal tunnel surgery	☐ Yes ☐ No
Lumbar spine (back) surgery	☐ Yes ☐ No	Prior ulnar nerve surgery	☐ Yes ☐ No
Hip/knee/foot surgery	☐ Yes ☐ No	Shoulder/elbow/wrist surgery	☐ Yes ☐ No

Current Medications: _____
_____

Do you have **allergies** to latex products? ☐ Yes ☐ No If yes, type or reaction _____
Do you have **allergies** to medications? ☐ Yes ☐ No If list, please list: _____

Are you on any **blood thinners?** ☐ Yes ☐ No **(**Ex: Warfarin/Coumadin, Plavix, Xarelto, Pradaxa)

Family History of a Peripheral Neuropathy or Muscle Disorder**?** ☐ Yes ☐ No

Social History:
Do you smoke? ☐ Yes ☐ No If yes, how much? _____
Do you drink alcohol? ☐ Yes ☐ No If yes, how much? _____

Gen: fever, chills, weight loss ☐ Yes ☐ No **If yes,** describe: _____
Neuro: sensory loss, fainting, seizures, headaches ☐ Yes ☐ No **If yes,** describe: _____
Endo: temp intolerance, excessive thirst, excessive urination ☐ Yes ☐ No **If yes,** describe: _____

Signature: _____Date: _____