Northwest Arkansas EMG Clinic
Miles M. Johnson, M.D.

Medical History Today's Date _____

Patient Name: _____SS#_____

Height: _____Weight:_____Age:_____Date of Birth_____

Personal Physician: Dr._____
Full name City, State

Consultation & EMG Test Requested By Dr. _____
Full name City, State

Date of return visit to Requesting Physician: _____

Have you seen Dr. Miles Johnson for EMG/NCV in past?_____If so, date_____

Please Circle all that apply:

Dominant Hand: Right Left

Problem Area: Neck Low Back Right Arm Left Arm

Right hand Left Hand Right Leg Left Leg Right Foot Left Foot

Symptoms: Pain Numbness Tingling Burning Weakness

Quality of Symptoms: Mild Moderate Severe

How long have you had symptoms? _____

Result of: Unknown Accident Injury Type of Accident/Injury:_____

IF Accident, STATE in which accident occurred:_____

Are the symptoms you are having: Increasing Decreasing or No Change in Severity

Are the symptoms: Constant or Intermittent (Females) Are you pregnant? Yes or No

What treatments have you tried for above:_____

Please Circle all that apply

(CONST): Fever Fatigue Night Sweats Weight Loss (DERM): Rashes

(VASC): Calf pain with Walking (GI/GU): Loss bowel/bladder control

(MUSC): Joint Pain Muscle Pain (HEMO): Bruising/Bleeding

(NEURO): Numbness Tingling Burning Weakness Balance Abnormalities

Double Vision Swallowing Problems Headaches Other (list):_____

Past Medical History

Diabetes: Yes or No Thyroid Disease Yes or No Allergy to Latex? Yes or No

Do you have: Heart Valve Replacement? _____ Defibulator?_____ Pacemaker?_____

Current Conditions/Illnesses:_____[]None-Healthy

Have you had Spinal or Extremity(arms/legs) Surgeries? (please list):_____

_____

Medications: _____

_____

Family Members with Nerve or Muscle problems? No or Yes _____

Do you smoke? Yes /No How Much? _____ Drink alcohol? Yes/No How Much? _____

Occupation type (be specific):_____OFFICE USE: Visitor:_____Emp____