

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	Ambidextrous		
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): Current _____ Previous _____

OFFICE USE: Visitor: _____ Emp _____ Miles M Johnson MD Sign _____