Northwest Arkansas EMG Clinic
Dr. Tyler Estes, MD

Medical History:

Date: ___/___/___

Last Name: _____ First Name: _____ MI: _____ Height: _____

ID #: _____ DOB: ___/___/___ Age: _____ Sex at Birth: ☐M ☐F Weight: _____

Referring Doctor: _____

Return Appointment Date with Referring Doctor: _____

Dominant Hand
Right
Left
Ambidextrous

Circle Problem Area(s) Today	
Neck	Low Back
Right Arm	Right Leg
Right Hand	Right Foot
Left Arm	Left Leg
Left Hand	Left Foot

Circle your Symptoms	
Pain	Burning
Numbness	Weakness
Tingling	Twitching

Rate/Circle the Severity of your Symptoms		
Mild	Moderate	Severe

How long have you experienced the symptoms? _____

What makes it worse? _____ What makes it better? _____

Do Not Write Below this Line (FOR OFFICE USE ONLY)

History: _____

_____

Medical History:

Diabetic	Y	N	Meds	Injection	A1C-	Type: 1 / 2
Cancer	Y	N	Chemo	Radiation		
Thyroid	Y	N	Hypo	Hyper		
Pacemaker	Y	N				
Smoker	Y	N	Length: _____			
Alcohol	Y	N				

Surgery: _____

Family History Neuro or Myo: _____

Exam:

Neck: _____

Motor: _____

Sensory: _____

Tinels: Wrist Elbow Tibial Fib Head

Phalens: + -

Back: _____

DTRs: _____

UMN: Hoffman's Babinksi Clonus

Gait: _____