



Welcome to the UT Erlanger Neuromuscular Clinic! In order to help us understand how we can be of greatest benefit to you, please complete the following:

Name: _____ Date of Birth: ____ / ____ / ____
Last First MI Month Day Year

for completion by medical staff:

Height: ____' ____" Weight: ____ lbs
 Feet Inches Pounds

BP: ____ Pulse: ____ Resp: ____ Temp: ____ Pain: ____ SI/HL: ____

Hand dominance (i.e. which hand to you write with)? Right Left

Please describe the primary reason for your visit today.

How long have you been experiencing these symptoms for?

What medical conditions have you been diagnosed with?

What surgical procedures have you undergone?

Please list your current prescription medications.

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Are you allergic to any medications or latex/tape? Yes No
(if so, please list) _____

Are you aware of anyone in your family (blood relative) that has been diagnosed with a disorder of the nerves or muscles?

Yes No

Do you currently use tobacco products? Yes No

Do you consume alcoholic beverages on a daily basis? Yes No

While being evaluated for your symptoms, have any of the following tests been performed (provide details if possible)?

Neuroimaging (e.g. MRI, CT scans)

Laboratory evaluation

Electrodiagnostic testing (EMG / Nerve Conduction Testing)

Patient Signature: _____ Date: ____ / ____ / ____

If minor, Parent or Legal Guardian Signature: _____

Neuromuscular Staff: Reviewed & signed by: _____