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

Date:_____

Last Name: _____ First Name: _____ Middle Int: _____

Height: _____ SS#: _____ DOB: _____ Age: _____
Weight: _____
Referring Doctor: _____

Return Appointment 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 what symptoms you are experiencing	
Pain	Burning
Numbness	Weakness
Tingling	

Rate/Circle the severity of your symptoms		
Mild	Moderate	Severe

How long have you experienced symptoms?: _____

What makes your symptoms worse?: _____ better? _____

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

History:_____
_____

Medical History:

Diabetic	Y	N	Meds	Injection	A1C-
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 Babinski Clonus
Gait: _____