alaska spine institute

Phone: 907.563.8876
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3801 University Lake Drive
Anchorage, AK 99508

Dear Patient:

Enclosed you will find a questionnaire regarding your past medical history and your current concerns. **We ask all our patients to please take the time to complete this questionnaire before your appointment. In the event you are unable to do so, we may need to reschedule your appointment.**

Please review the pre-appointment instructions prior to your appointment, which is scheduled on _____ at _____ with _____, at the _____ facility. Please call our office, before your appointment, to pre-register. The phone number is (907) 563-8876 or toll free 866-637-3422.

On the day of your appointment we ask that you **do not** wear any **lotion, oil or powder.** This may affect the results of the EMG/NCV testing.

Sincerely,

**Alaska Spine Institute Providers**

**Larry Levine, MD**
**Michel Gevaert, MD**
**Shawn Johnston, MD**
**Erik Olson, DO**
**Hyon Joo, DO**

# Electrodiagnostic Testing

**NAME:**_____ **DATE:**_____

**DATE OF BIRTH:** _____ **AGE:** _____ **SEX: M F**

**REFERRING PHYSICIAN:** _____

**WHEN DID YOUR SYMPTOMS BEGIN?** _____

**IS THIS WORK RELATED?** _____

**DESCRIBE YOURCOMPLAINTS:**_____

_____

_____

_____

_____

**SYMPTOMS ARE WORSENED WITH:** _____

_____

**SYMPTOMS ARE IMPROVED WITH:** ☐ **Rest/Bed** ☐ **Lying down** ☐ **Walking/Standing** ☐ **Time of day**

☐ **Being around people** ☐ **Sexual activity** ☐ **Physical activity** ☐ **Drugs** ☐ **Exercise** ☐ **Other** _____

**RECENT PRIOR TESTING:**

| TEST | WHEN | WHERE |
|---|---|---|
| X-RAYS | | |
| CT SCAN/ MRI | | |
| EMG/NCV | | |
| OTHER | | |

**PAST MEDICAL HISTORY:**

❑ **Diabetes** ❑ **High blood pressure** ❑ **Hepatitis** ❑ **Thyroid Disease** ❑ **Ulcer**
❑ **Cancer** **If so what kind?**_____ ❑ **Heart Disease** ❑ **Tuberculosis** ❑ **Lung Disease**
❑ **Kidney Disease** ❑ **Arthritis** ❑ **Depression** ❑ **Other Illnesses** _____

**Prior Hospitalization:**_____

**Surgical History ( Procedure and Year):**_____

_____

***TURN PAGE OVER AND COMPLETE OTHER SIDE***

**FAMILY HISTORY:**

❑ **Diabetes** ❑ **High blood pressure** ❑ **Cancer** **If so what kind** _____ ❑ **Heart Disease**
❑ **Depression** ❑ **Disability** ❑ **Chronic pain** ❑ **Stroke** ❑ **Alcoholism** ❑ **Migraine**
❑ **Other** _____

**SOCIAL HISTORY: Occupation_____ Currently Working? YES NO**

**Smoke: YES NO How much? _____ How Long? _____**

**Alcohol: YES NO How much?_____ How Long?_____**

**Marital Status** ❑ **Married** ❑ **Single** ❑ **Divorced** ❑ **Separated** ❑ **Widowed** **How long?** _____

**MEDICATIONS:**_____

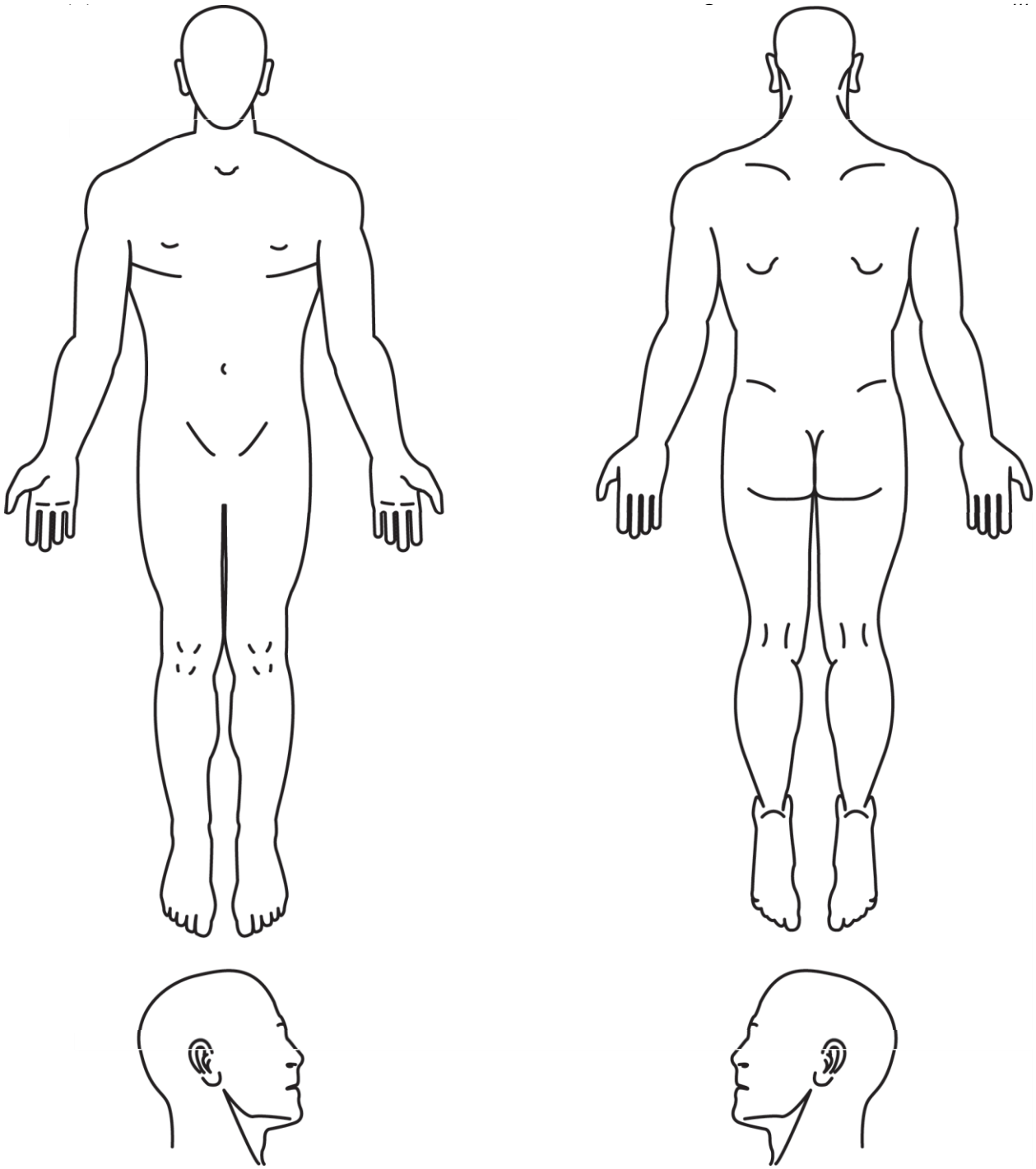
_____

**ALLERGIES:** _____

**YOU MAY USE THE AREA BELOW FOR ANY ADDITIONAL COMMENTS OR INFORMATION THAT YOU FEEL IS IMPORTANT REGARDING YOUR CURRENT MEDICAL CONDITION.**

**Complete the following diagram drawing the symbols below to show where you have your typical pain**

Ache ➢➢ Numbness ■ Pins and Needles ○ Burning Stabbing ///



What is your average pain? Or give a range of your level of pain.
"0" indicates NO PAIN and "10" indicates pain so severe it would cause you to faint or lose consciousness

0 1 2 3 4 5 6 7 8 9 10

Patient Name:_____ Date of Birth:_____

Please review the following list of medical problems and mark any that apply to you *now* or in the past. Please go over the list carefully. Medical problems that do not seem related to your current situation could result in a serious complication if you do not let us know about them.

## Constitutional

- ☐ Recent weight gain: ____ lbs
- ☐ Recent weight loss: ____ lbs
- ☐ Fever or soaking sweats at night
- ☐ Fatigue
- ☐ Weakness/numbness of arms/legs
- ☐ Headaches ≥1-2 times per week
- ☐ Difficulty walking
- ☐ Loss of consciousness/convulsions

## Eyes

- ☐ Vision problems not corrected by glasses
- ☐ Glaucoma
- ☐ Eye lens implant
- ☐ Eye prosthesis
- ☐ Contact lenses

## Ears, Nose, Throat

- ☐ Chronic stuffy nose or nasal polyps
- ☐ Frequent nosebleeds
- ☐ Sinus problems
- ☐ Hay fever allergies
- ☐ Difficulty hearing
- ☐ Ear infections
- ☐ Hearing aid
- ☐ Chronic sore throat or tonsillitis
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Dentures or partial plates
- ☐ Capped teeth
- ☐ Loose teeth
- ☐ Orthodontic braces

## Cardiovascular

- ☐ Heart murmur
- ☐ Prolapsed mitral valve
- ☐ Heart pacemaker
- ☐ Irregular heartbeat
- ☐ Palpitations or rapid pulse
- ☐ Fainting spells
- ☐ Chest pain or angina on exertion
- ☐ Chest pain or angina at night
- ☐ Heart attack
- ☐ Congestive heart failure
- ☐ Swelling in feet or ankles
- ☐ Shortness of breath lying flat
- ☐ Shortness of breath at night
- ☐ Blood clots or pulmonary embolism
- ☐ High blood pressure
- ☐ Low blood pressure

## Respiratory

- ☐ Asthma or wheezing
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Chronic cough
- ☐ Change in amount of phlegm
- ☐ Change in color of phlegm
- ☐ Coughing up blood
- ☐ Collapsed lung
- ☐ Tuberculosis exposure
- ☐ Blueness of your fingernails

## Gastrointestinal

- ☐ Ulcers
- ☐ Hiatal hernia or frequent heartburn
- ☐ Ulcerative colitis
- ☐ Diverticulitis
- ☐ Colostomy or other 'ostomy'
- ☐ Hepatitis or yellow jaundice
- ☐ Liver cirrhosis
- ☐ Gallbladder problems
- ☐ Vomiting blood
- ☐ Black, tarry bowel movements
- ☐ Blood in bowel movements
- ☐ Change in bowel habits

## Genitourinary

- ☐ Kidney stones
- ☐ Kidney infections
- ☐ Kidney failure
- ☐ Dialysis
- ☐ Prostate problems
- ☐ Bladder infections
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Do you lose your urine at times

## Musculoskeletal

- ☐ Fractures or broken bones
- ☐ Arthritis
- ☐ Difficulty opening mouth wide
- ☐ Scoliosis
- ☐ Spinal column deformity

## Integumentary/Dermatologic

- ☐ Skin rash or sores
- ☐ Itching
- ☐ Color change, pigmentation, nodules
- ☐ Pressure ulcers

## Neurologic

- ☐ Seizures or convulsions
- ☐ Epilepsy
- ☐ Stroke
- ☐ Brain aneurysm or hemorrhage
- ☐ Multiple Sclerosis
- ☐ Nerve Injury or Numbness

## Psychiatric

- ☐ Depression
- ☐ Anxiety or panic attacks
- ☐ Mental disorder

## Endocrine

- ☐ Diabetes
- ☐ Insulin use
- ☐ Low blood sugar or hypoglycemia
- ☐ Thyroid problems
- ☐ Steroid use

## Allergic/Immunologic

- ☐ Herpes exposure
- ☐ AIDS exposure
- ☐ Street drug use

## Hematologic

- ☐ Abnormal bleeding problems
- ☐ Anemia or low blood count
- ☐ Blood transfusion
- ☐ Hemophilia
- ☐ Sickle cell anemia

## Lymphatic

- ☐ Swollen glands or masses in neck, axillae, groin
- ☐ Lymphedema

## Others

- ☐ Sexual problems
- ☐ Muscular dystrophy
- ☐ Myasthenia gravis
- ☐ Malignant hyperthermia
- ☐ Bad reaction to local anesthetic
- ☐ Down syndrome
- ☐ Cancer or tumor
- ☐ Chemotherapy
- ☐ Radiation therapy
- ☐ Recent acute illness
- ☐ Recent hospitalization
- ☐ Recent surgical operation

*Use the back of this page to list any problems not already covered that you consider important*

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***For women only***:

Are you pregnant? ☐ Yes ☐ No
Are menstrual periods normal? ☐ Yes ☐ No
☐ Any vaginal discharge
☐ Bleeding between periods
☐ Bleeding after menopause

Number of pregnancies: _____
Number of deliveries: _____
Date of last menstrual period: _____
Approx date of last pap smear: _____

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I have carefully reviewed this checklist and completed it to the best of my knowledge. Date: _____

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***Signature of Patient, Parent, or Guardian*** ***Relationship to patient, (if not self)***

Patient Name:_____ Date of Birth:_____