

Neurosurgical Associates at St Francis



Medical History Questionnaire for Peripheral Nerve

Patient's name _____ D.O.B. _____ Age _____

Was there an accident or injury that you are aware of? _____

When did your symptoms begin? _____

Describe your symptoms _____

Do you have arm numbness or tingling? Y N Where _____

Describe _____

Have you noticed a loss of grip or strength? _____

Do you have shooting pain? Y N Where? _____

Is it constant or intermittent? (circle one)

Have you experienced muscle twitching? _____

Describe it _____

What improves your pain? _____

What aggravates the pain? _____

Have you had Physical Therapy or seen another physician for this problem? Y N if so, who / where? _____

Have you had an EMG? Y N Where _____

What treatment have you received? (please check) Physical therapy splints

Are your symptoms getting worse, improving, or staying the same? _____

On a scale of 1-10 with 10 being the worst possible pain, please rate your pain _____

Factors That May Affect Learning

Who is to be taught?: patient other; if other, relationship to patient _____

Able to read?: yes no with difficulty Comments _____ Potential

barriers to learning: none blind poor vision deaf decreased hearing unable to talk

learning disability inability to understand memory loss language, if other than English _____

Learns best by: reading verbal instruction practicing talking watching other, _____

Are there any cultural or religious beliefs that need to be considered in the care? yes no

If yes, _____

Signature _____ Relationship to patient _____ Date _____

Staff review date & initials _____