



# BURLINGTON NEUROLOGY & SLEEP CLINIC, PLC.

## TREATMENT OF:

Neurology  
Dementia  
Epilepsy  
Headaches  
Multiple Sclerosis  
Parkinson's Disease  
Sleep Disorders

## EMG Exam Intake Sheet

Date: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood pressure: \_\_\_\_\_ Pt #: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Referred by: \_\_\_\_\_ Reason for Appointment: \_\_\_\_\_

Age: \_\_\_\_\_ Sex:  Male  Female Handed:  Right  Left

Past Medical Problems: \_\_\_\_\_

Previous Surgeries: \_\_\_\_\_

Do you have a history of:

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> Migraines    | <input type="checkbox"/> Work Injuries          |
| <input type="checkbox"/> Hypertension         | <input type="checkbox"/> Peptic Ulcer | <input type="checkbox"/> Motor Vehicle Accident |
| <input type="checkbox"/> Elevated Cholesterol | <input type="checkbox"/> Asthma       | <input type="checkbox"/> Seizures               |
| <input type="checkbox"/> Angina               | <input type="checkbox"/> Stroke       | <input type="checkbox"/> Thyroid Dysfunction    |

Medication you are taking now: \_\_\_\_\_

Medication Allergies: \_\_\_\_\_

Are you having any of these symptoms (Lack of a response means you are not having the symptom):

SYSTEMIC	HEENT	NECK	PULMONARY	CARDIOVASCULAR	GASTROINTESTINAL
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Headache	<input type="checkbox"/> Neck pain	<input type="checkbox"/> Short of breath	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/> Chills	<input type="checkbox"/> Vision Problems	<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Cough	<input type="checkbox"/> Fast heart rate	<input type="checkbox"/> Heartburn
<input type="checkbox"/> Fever	<input type="checkbox"/> Nosebleeds	<input type="checkbox"/> Lump/swelling in neck	<input type="checkbox"/> Cough w/ blood	<input type="checkbox"/> Palpitations	<input type="checkbox"/> Nausea
<input type="checkbox"/> Night Sweats			<input type="checkbox"/> Wheezing		<input type="checkbox"/> Vomiting
					<input type="checkbox"/> Abdominal pain
					<input type="checkbox"/> Diarrhea

GENITOURINARY	SKIN	HEMATOLOGICAL	PSYCHOLOGICAL	ENDOCRINE
<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Itching of skin	<input type="checkbox"/> Easy bleeding	<input type="checkbox"/> Sleep disturbance	<input type="checkbox"/> Excessive sweating
<input type="checkbox"/> Difficulty/pain w/ urination	<input type="checkbox"/> Skin lesions	<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Depression	<input type="checkbox"/> Excessive thirst
<input type="checkbox"/> Increased frequency	<input type="checkbox"/> Rash		<input type="checkbox"/> Anxiety	

What medical conditions are present in your family?

Father: \_\_\_\_\_ Brother (s): \_\_\_\_\_

Mother: \_\_\_\_\_ Sister(s): \_\_\_\_\_

Children: \_\_\_\_\_

## Social History

Do you smoke?  Yes  No How much? \_\_\_\_\_

Do you drink alcohol?  Yes  No How much: \_\_\_\_\_

Do you work?  Yes  No What type of job? \_\_\_\_\_

What family or friends live with you? \_\_\_\_\_

(EMG Intake Sheet 2/12)

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