Norman J. Torres MD
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ASSESSMENT OF PERIPHERAL NERVE

Patient Name _____ Date of Birth_____

Age: _____ Height: _____Weight: _____Sex (circle one): Male Female

Marital Status (circle one): Single – Married – Divorced - Widowed

PATIENT HISTORY

Briefly describe the symptoms you are experiencing including the dates and when they began to get worse.

_____

_____

_____

_____

Is the reason for your visit work related? (Circle One) YES NO

If yes, please state the date of injury_____

Complaint: (Check if applicable)

	Yes	No	Right Side	Left Side	Additional Notes (include location)
Burning Sensation					
Loss of Balance					
Sweating					
Weakness					
Numbness					
Tingling					

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Patient Name _____

Are bladder functions normal? (Circle One) YES NO

Are bowel functions normal? (Circle One) YES NO

Any changes in walking? (Circle One) YES NO

How long have you had the above symptoms? (Circle One) DAYS WEEKS YEARS

What treatment have you had for the above symptoms?

	Yes	No	Please specify
Anti-Inflammatory			
Muscle Relaxant			
Pain Reliever			
Physical Therapy			
Steroid Injections			
Cervical Traction			

What testing have you had for the above symptoms?

	Yes	No	Date	Where
Plain X-rays				
MRI				
Myelogram				
CT Scans				
EMG/NCS				
Other				

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Patient Name _____

SOCIAL AND OCCUPATIONAL HISTORY

Occupation: _____

Does your job require you to lift? _____ How much?_____ Right or Left handed?_____

Do you or have you ever used Tobacco products? (Circle One) YES NO

Do you or have you ever used Alcoholic Beverages? (Circle One) YES NO

Do you or have you ever used Street Drugs? (Circle One) YES NO

MEDICATIONS AND ALLERGIES

Are you allergic to any medication? (Circle One) YES NO

Please list any if answered YES:

_____

_____

_____

_____

List any medication you are currently taking including amount and frequency:

Medication	Dosage	Frequency

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Patient Name _____

PERSONAL MEDICAL HISTORY

List any Surgeries with dates which you have had:

Surgery	Date

List any serious illnesses, injuries and/or accidents including dates:

Illness	Date

Do you have or have ever had:

Glaucoma	Yes	No	Thyroid Disorder	Yes	No	Bronchitis	Yes	No
Pneumonia	Yes	No	Diabetes	Yes	No	Tonsillitis	Yes	No
Asthma	Yes	No	Hepatitis	Yes	No	Colitis	Yes	No
Cholesterol	Yes	No	Arthritis	Yes	No	Suicide	Yes	No
High Blood Pressure	Yes	No	Kidney Disease	Yes	No	Bladder Infection	Yes	No
Stroke	Yes	No	Anxiety	Yes	No	Gall Stones	Yes	No
Heart Attack	Yes	No	Seizures	Yes	No	Stomach Ulcers	Yes	No
Rheumatic Heart	Yes	No	Depression	Yes	No	Blood Clots	Yes	No
Congenital Heart	Yes	No	Alzheimer's/Dementia	Yes	No	Bleeding Tendency	Yes	No
Heart Failure	Yes	No	Cancer _____	Yes	No	Migraine	Yes	No
Heart Disease	Yes	No	Tuberculosis	Yes	No	High Fever	Yes	No
Murmur	Yes	No	AIDS/HIV	Yes	No	Other:_____		

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Patient Name _____

FAMILY MEDICAL HISTORY

Do you have knowledge of any direct relative who has or has had any of the following:

Asthma	Yes	No	Arthritis	Yes	No	Bladder Infection	Yes	No
Cholesterol	Yes	No	Kidney Disease	Yes	No	Alzheimer's/Dementia	Yes	No
High Blood Pressure	Yes	No	Depression	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Glaucoma	Yes	No	Suicide	Yes	No
Heart Attack	Yes	No	Bronchitis	Yes	No	Blood Clots	Yes	No
Rheumatic Heart	Yes	No	Tonsillitis	Yes	No	Bleeding Tendency	Yes	No
Congenital Heart	Yes	No	Pneumonia	Yes	No	Tuberculosis	Yes	No
Heart Failure	Yes	No	Back Problem	Yes	No	Hepatitis	Yes	No
Heart Disease	Yes	No	Neck Problem	Yes	No	AIDS/HIV	Yes	No
Murmur	Yes	No	Migraine	Yes	No	Colitis	Yes	No
Diabetes	Yes	No	Gall Stones	Yes	No	High Fever	Yes	No
Thyroid Disorder	Yes	No	Stomach Ulcers	Yes	No	High Fever(after surgery)	Yes	No
Cancer _____	Yes	No	Anxiety	Yes	No	Other:_____		

I certify that I have filled out the above information to the best of my knowledge.

Signature_____Date_____