Vancouver CoastalHealth
Promoting wellness. Ensuring care.

The Neuromuscular Diseases Unit
Vancouver Hospital & Health Sciences Center
2775 Laurel St., Vancouver, BC, V5Z 1M9
Phone: (604) 875-4405 Fax: (604)875-5867

Patient Information – Questionnaire

Please complete the following and return to clerk when arriving for your appointment.

Full Name: _____ Age:____ ☐ Right-handed ☐ Left-handed ☐ Ambidextrous

Weight: _____ Height: _____ Highest level of education: _____

Occupation: _____

Please describe the PROBLEM(S) you have that relate to this appointment:

Is this problem related to: ☐ WCB ☐ ICBC ☐ Date of Accident: _____

When did this problem start or how long have you had this problem: _____

Background Health

Please mark if you have any of the following

☐ Diabetes	☐ Thyroid Disease	☐ Heart Disease	☐ High Blood Pressure
☐ Cancer	☐ HIV	☐ Ulcers	☐ Arthritis
☐ Migraine	☐ Epilepsy	☐ Multiple Sclerosis	☐ Peripheral Nerve Disease

Please list any previous Surgeries, Accidents and/or Medical Problems not listed above:

_____ Date/Year_____
_____ Date/Year_____
_____ Date/Year_____

Current Medications and dose (please include vitamin and herbal supplements):

Smoke	☐ Yes	☐ No	if yes, how much _____
Marijuana	☐ Yes	☐ No	if yes, how much _____
Drink Alcohol	☐ Yes	☐ No	if yes, how much _____
Illicit Drugs	☐ Yes	☐ No	if yes, what and frequency _____
Allergies:	☐ Yes	☐ No	if yes, please list: drug, seasonal or other

Have you had any of the following test(s)?

☐ CT Scan / MRI (select one) Location/Date: _____
☐ EMG/Nerve Conduction Studies Location/Date: _____
☐ Nerve Biopsy Location/Date: _____

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Have you ever taken any of the following medications in the past?

□ Gabapentin (Neurontin) □ Amitriptyline (Elavil) □ Pregabalin/Lyrica

□ Nortriptyline □ Morphine/Other pain killers □ IVIG

Family History:	**Age? / Alive?**	**Health problems or cause of death**
•Mother	_____/_____	_____
•Father	_____/_____	_____
•Sister(s)	_____/_____	_____
•Brother(s)	_____/_____	_____
•Children	_____/_____	_____

Upper/Lower Limb symptoms:

I have numbness in: □ **arm** □ hand □ right □ left □ other? _____

□ **leg** □ foot □ right □ left □ other? _____

Symptoms are worse: □ at night □ daytime □ always

Are your symptoms aggravated by activity? ☐ Yes ☐ No If yes, what? _____

Are you wearing a wrist brace? ☐ Yes ☐ No How long? _____

Have you had previous Carpal Tunnel Surgery? ☐ Yes ☐ No If yes, when? _____
□ right □ left □ both

Has anyone else in your family have: □ Carpal Tunnel Syndrome? □ Muscle or Nerve problems?

Do you have: □ Neck Pain □ Back pain □ Cramps □ Muscle weakness

Peripheral Neuropathy:

Do you have any of the following symptoms?
Where on your body do these occur?
Since when?

□ Pain _____
□ Numbness _____
□ Weakness _____
□ Imbalance _____
□ Tremor of the hands _____

Does anyone in your family have very thin lower legs or high arched feet? □ Yes □ No

Do you have any of the following additional symptoms?

Lightheadedness when you stand up?	☐ Yes	☐ No	Weight loss?	☐ Yes	☐ No
Bloating or gas after meals?	☐ Yes	☐ No	Night Sweats?	☐ Yes	☐ No
Urinary problems?	☐ Yes	☐ No	Bowel problems?	☐ Yes	☐ No
Fatigue?	☐ Yes	☐ No	Change in sweating?	☐ Yes	☐ No
Sexual difficulties?	☐ Yes	☐ No			