1. Please describe the primary symptom(s) that resulted in a referral for this test:
___________________________________________________________________________________

2. How long have these symptoms been going on for?
___________________________________________________________________________________

3. Are you aware of any specific cause(s) for these symptoms, such as an injury? yes / no (circle one)
If YES, please explain:________________________________________________________________

4. How have these symptoms changed since onset?
They've worsened / improved/ fluctuated / no change (circle one)

5. What describes the nature of your symptoms? Circle all that apply.
   Numbness       Sharp pain       Weakness
   Tingling       Dull pain (ache)  Muscle atrophy
   Burning        Shooting pain    Color changes in skin
   Cold feeling   Pain with exercise or walking  Skin symptoms
   Other: ___________________________________________________________

6. What part(s) of your body is/are affected by these symptoms?
___________________________________________________________________________________

7. Carefully use diagram to identify the EXACT location of your symptoms
8. Are your symptoms present continuously or intermittently (circle one)?
If intermittent, about how long do they typically last at a time?
___________________________________________________________________________________

9. Are they worse in the morning, afternoon, or evening? (circle one)
Do they wake you up at night? yes / no

10. Are there any activities that make your symptom(s) worse? yes / no If so, which ones?
___________________________________________________________________________________

11. Is there anything that makes them better? yes / no
If YES, what?
___________________________________________________________________________________

12. Do you have NECK pain? yes / no
Do you have any pain shooting down either arm from the neck? yes/ no
If so, which side? right / left / both
What parts of the arm/forearm/hand/fingers are affected by this pain?
[ ] Same as #7
[ ] If different, describe:_______________________________________________________________

13. Is this NECK pain worsened by any of the following (circle any that apply): NONE OF THESE
   Coughing
   Sneezing
   Laughing
   Straining during a bowel movement
   Moving the head or neck in any particular direction
   If Yes, which direction: _______________________________________

14. Do you have BACK pain? yes / no
Do you have any pain shooting down either thigh/calf/foot from the back? yes/ no
If so, which side? right / left / both
What parts of the thigh/calf/foot are affected?
[ ] Same as #7
[ ] If different, describe:_______________________________________________________________

15. Is this BACK pain worsened by any of the following (circle any that apply): NONE OF THESE
   Coughing
   Sneezing
   Laughing
   Walking
   Sitting
   Lying down
   Straining during a bowel movement
   Bending forwards
   Bending backwards
   Other: _____________________________________________________________
16. Do you have any muscle weakness? **yes / no**

If so, which body parts are affected (circle all that apply):

- Face
- Right arm
- Left arm
- Neck
- Right hand
- Left hand
- Torso
- Right thigh
- Left thigh
- Right calf
- Left calf
- Right ankle
- Left ankle
- Right foot
- Left foot

During what types of activities is your weakness most notable? ____________________________________________________

17. Do you have difficulty with any of the following activities because of muscle weakness (circle those that apply)?

- Walking upstairs
- Shampooing your hair
- Writing
- Walking downstairs
- Driving
- Getting into or out of a car/chair
- Buttoning your clothes
- Gripping/opening things
- Moving things on/off shelves (a) with your right hand (b) with your left hand

18. Do you have any trouble keeping balance? **yes / no**

19. Have you undergone any testing (MRI, X-ray, prior nerve conduction / EMG study) for your symptoms to date? **yes / no**  If so, what tests and where?

___________________________________________________________________________________

20. Have you undergone any treatments or surgeries for your symptoms to date? (for example: carpal tunnel release surgery, ulnar nerve surgery, cervical / lumbar spine surgery)

<table>
<thead>
<tr>
<th>Surgery/Treatment</th>
<th>Date</th>
<th>Location</th>
<th>Surgeon</th>
</tr>
</thead>
<tbody>
<tr>
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</tbody>
</table>

21. Have you ever been diagnosed with diabetes? **yes / no**

If YES: Approximately when were you diagnosed? ___________ (date)

Do you take insulin for this issue? **yes / no**

What was your most recent Hemoglobin A1C (example: 6.5): _______

22. Have you ever been diagnosed with cancer? **yes / no**

If YES: What type? __________________________

Have you ever had chemotherapy? **yes / no ** ___________ (date)

Have you ever had radiation therapy? **yes / no ** ___________ (date)
23. Have you ever been diagnosed with any of the following conditions?

<table>
<thead>
<tr>
<th>Y</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding disorder</td>
<td>Y</td>
</tr>
<tr>
<td>Lupus</td>
<td>Y</td>
</tr>
<tr>
<td>Urinary problems</td>
<td>N</td>
</tr>
<tr>
<td>Bowel problems</td>
<td>Y</td>
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<tr>
<td>Sexual dysfunction</td>
<td>N</td>
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<tr>
<td>Shortness of breath / lung disease / COPD</td>
<td>Y</td>
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<tr>
<td>Vitamin B12 deficiency</td>
<td>N</td>
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<tr>
<td>Arthritis</td>
<td>Y</td>
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<tr>
<td>Stomach problems or ulcers</td>
<td>Y</td>
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<tr>
<td>Kidney problems</td>
<td>N</td>
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<tr>
<td>Liver problems</td>
<td>N</td>
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<tr>
<td>Alcohol / drug abuse</td>
<td>Y</td>
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<tr>
<td>Depression / anxiety / bipolar</td>
<td>Y</td>
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<tr>
<td>Other:</td>
<td>N</td>
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<tr>
<td>High blood pressure</td>
<td>N</td>
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<tr>
<td>High cholesterol</td>
<td>N</td>
</tr>
<tr>
<td>Heart disease</td>
<td>N</td>
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<tr>
<td>Stroke / TIA</td>
<td>Y</td>
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<tr>
<td>Obesity</td>
<td>N</td>
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<tr>
<td>Peripheral arterial disease</td>
<td>N</td>
</tr>
<tr>
<td>Other:</td>
<td>N</td>
</tr>
</tbody>
</table>

24. Does anyone in your family have nerve or muscle disease, or have symptoms similar to yours? **yes/no**

25. Do you use blood thinners? **yes / no** Do you have a latex allergy? **yes / no**

Thank you for taking the time to complete this health questionnaire. We will review additional details during today's visit.

NeuroDx Team