Please complete the following questionnaire and bring it with you to your appointment with Dr Selk. Thank you.

Name: _____

When did your symptoms begin?

Are you □ Right-handed or □ Left-handed?

Do you have any of the following:

- Fever: □ No □ Yes
- Chills □ No □ Yes
- Night Sweats: □ No □ Yes
- Pain: □ No □ Yes If yes, where?

_____

If yes, is it: □ sharp □ dull □ aching □ burning □ electrical/shock-like □ other_____

If yes, is it □ constant or □ comes and goes?

Are symptoms worse at night? □ No □ Yes

Do symptoms wake you in night? □ No □ Yes

List any medical conditions that have been diagnosed by a doctor: (ie thyroid, diabetes)

List any medications that you currently take:

List any surgeries you have had and when:

Do you have any allergies? □ No □ Yes If yes, what?

_____

Do you smoke? □ No □ Yes If yes, how much? _____/ day x ____years

Do you ever drink alcohol? □ No □ Yes If yes how much per week?
_____

Do you use illicit substances? (ie: marijuana, IV drugs) □ No □ Yes If yes, what?
_____

Is there any family history of nerve disease, early cane use,
_____

Would you consent to be contacted in the future for any:
· Research projects from this department? □ Yes □ No
· Teaching projects from this department? □ Yes □ No

Person completing this form: _____ Relationship to patient: _____

Date: _____