NEUROLOGY CONSULTANTS MEDICAL GROUP

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NAME: _____ DATE: _____

HAVE YOU HAD ANY OF THE FOLLOWING TESTS PERFORMED?

Test Performed	*Date Performed*	*Location*
☐ ELECTROMYOGRAPHY (EMC) ☐ NERVE CONDUCTION VELOCITY (NCV)		
MAGNETIC RESONANCE IMAGING (MRI) ☐ BRAIN ☐ CERVICAL SPINE ☐ OTHER		
CAT SCAN ☐ BRAIN ☐ NECK ☐ OTHER		
☐ CAROTID ULTRASOUND (DOPPLER) ☐ TRANSCRANIAL DOPPLER ☐ ELECTROENCEPHALOGRAM (EEG)		
EVOKED POTENTIAL TESTS ☐ SOMATOSENSORY EVOKED POTENTIALS (SER) ☐ VISUAL EVOKED POTENTIALS (VER) ☐ BRAINSTEM AUDITORY EVOKED POTENTIALS (BAER)		