PREMEDICATION FOR ELECTROMYOGRAPHIC EXAMINATION

NAME: ______________________________ DOB: _______________

PHONE NUMBER: ____

WEIGHT: ___________________ PCP: _________________________

PHARMACY NAME: _____________________ PHARMACY PHONE:__________

ALLERGIES:____

PAST MEDICAL HISTORY: ______________________________________

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CURRENT MEDICATIONS: _______________________________________

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PERSON GIVING INFO: ________________________________

DATE OF APPOINTMENT: ______________________________