

Referring physician's name and address (if known): \_\_\_\_\_  
 \_\_\_\_\_

What is the main reason you are in this clinic? \_\_\_\_\_  
 \_\_\_\_\_

Do you presently have any problems in the following areas? If "Yes", please explain below:

	YES	NO		YES	NO
<b>General</b>			<b>Neurologic</b>		
Fever, Chills	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>
Change in weight	<input type="checkbox"/>	<input type="checkbox"/>	Weakness	<input type="checkbox"/>	<input type="checkbox"/>
			Numbness / tingling	<input type="checkbox"/>	<input type="checkbox"/>
<b>Eyes</b>			Coordination difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Visual blurring or loss at up close	<input type="checkbox"/>	<input type="checkbox"/>	Loss of smell/taste	<input type="checkbox"/>	<input type="checkbox"/>
Visual blurring or loss at distance	<input type="checkbox"/>	<input type="checkbox"/>	Speech / swallowing difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Distorted vision	<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss / ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Loss of side vision	<input type="checkbox"/>	<input type="checkbox"/>			
Vision worse in bright light	<input type="checkbox"/>	<input type="checkbox"/>	<b>Other</b>		
Visual hallucinations	<input type="checkbox"/>	<input type="checkbox"/>	Heart / blood vessels	<input type="checkbox"/>	<input type="checkbox"/>
Eye pain / soreness / burning	<input type="checkbox"/>	<input type="checkbox"/>	Respiratory (lungs / breathing)	<input type="checkbox"/>	<input type="checkbox"/>
Lazy eye	<input type="checkbox"/>	<input type="checkbox"/>	GI (stomach / intestine / liver)	<input type="checkbox"/>	<input type="checkbox"/>
Double vision	<input type="checkbox"/>	<input type="checkbox"/>	GU (genitals / kidney / bladder)	<input type="checkbox"/>	<input type="checkbox"/>
Droopy eyelids	<input type="checkbox"/>	<input type="checkbox"/>	Muscles / bones / joints	<input type="checkbox"/>	<input type="checkbox"/>
			Integument (skin / breast)	<input type="checkbox"/>	<input type="checkbox"/>
<b>Ears/Nose/Throat</b>			Blood / Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>
Sinus congestion	<input type="checkbox"/>	<input type="checkbox"/>	Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>
Noise in ear or head	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Jaw pain with chewing	<input type="checkbox"/>	<input type="checkbox"/>			

Please use the following space to briefly explain any problems indicated in above section.

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**OVER --- PLEASE COMPLETE OTHER SIDE**

**PAST HISTORY**

Diseases you are being treated for:

Medication(s) for corresponding disease (dose and frequency)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Other diseases: \_\_\_\_\_

Other Medications: (including nonprescription) \_\_\_\_\_

Medicine Allergies: \_\_\_\_\_

Hospitalizations: \_\_\_\_\_

Accidents and Trauma: \_\_\_\_\_

Surgeries: \_\_\_\_\_

Other: \_\_\_\_\_

**FAMILY HISTORY**

**Diseases**

- Blindness
- Migraine
- Diabetes
- Heart disease
- High blood pressure
- Stroke / TIA
- Other:
- Other: \_\_\_\_\_

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

RELATIONSHIP TO PATIENT

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**SOCIAL HISTORY:** Current occupation: \_\_\_\_\_

- Are you disabled?
- Do you drink alcohol?
- Do you smoke?

YES	NO
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

for how long: \_\_\_\_\_  
\_\_\_\_\_ drinks per day / week / month  
\_\_\_\_\_ packs per day for \_\_\_\_\_ years

Please use the following space to briefly explain any problems indicated in above sections:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

History reviewed  No Changes  Additions as noted above

Physicians signature: \_\_\_\_\_ Date: \_\_\_\_\_