ent's Name	ate	Age_	Sex	Pt #
please print				An - Are - A
ctions: Please circle the correct respon	nse. Sign and	d date	e when	completed.
HISTORICAL INFORMATION				DOCTOR'S NOTE
Have you ever been diagnosed or told	you had any			
of the following?	,			
1. High Blood pressure (hypertension)		Yes	No	
2. Hardening of the arteries (arterioscl	erosis)	Yes		
3. Diabetes	<i>1</i>	Yes		
4. Heart or blood vessel diseases		Yes		
5. Bone spurs on the neck bones (cen	rical	1	.,,	
spondylosis)		Yes	No	9
6. Whiplash injury (flexion-extension in	ury)		, RONG	
(cervical sprain)		Yes	No	
7. Have any of your relatives ever suff	ered a			
stroke?		Yes	No	
Were you ever a smoker? From	_To	Yes	No	
9. Do you take any medication on a r	egular basis?	Yes	No	
10. (Women only) Have you ever taker	oral			
contraceptives? FromT	0	Yes	No	
even short temporary attacks?				
11. Blurred vision?			No	
11. Blurred vision? 12. Double vision?	one or		No No	
11. Blurred vision?12. Double vision?13. Diminished or partial loss of vision in	one or	Yes	No	
11. Blurred vision?12. Double vision?13. Diminished or partial loss of vision in both eyes?		Yes Yes	No No	
11. Blurred vision?12. Double vision?13. Diminished or partial loss of vision in both eyes?14. Complete loss of vision in one or both	th eyes?	Yes Yes Yes	No No No	
11. Blurred vision?12. Double vision?13. Diminished or partial loss of vision in both eyes?	th eyes?	Yes Yes Yes	No No	
 Blurred vision? Double vision? Diminished or partial loss of vision in both eyes? Complete loss of vision in one or both. Ringing, buzzing or any noise in the learing loss in one or both ears? Slurred speech or other speech pro 	th eyes? ear(s)?	Yes Yes Yes Yes	No No No No	
 11. Blurred vision? 12. Double vision? 13. Diminished or partial loss of vision in both eyes? 14. Complete loss of vision in one or both. Ringing, buzzing or any noise in the 16. Hearing loss in one or both ears? 17. Slurred speech or other speech pro 18. Difficulty swallowing? 	th eyes? ear(s)?	Yes Yes Yes Yes Yes	No No No No	
 11. Blurred vision? 12. Double vision? 13. Diminished or partial loss of vision in both eyes? 14. Complete loss of vision in one or both. 15. Ringing, buzzing or any noise in the 16. Hearing loss in one or both ears? 17. Slurred speech or other speech pro 18. Difficulty swallowing? 19. Dizziness? 	th eyes? ear(s)?	Yes Yes Yes Yes Yes Yes	No No No No No No No	
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