Nancy M. Mackowsky, OD, PA

The Mackowsky
Visual Learning &
Rehabilitation Clinic

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Adult Medical Questionnaire

IMPORTANT: Please fill out this questionnaire in black ink and bring with you to your appointment. The information on this form will enable Dr. Mackowsky to ascertain and evaluate your needs most effectively. Please also forward any other pertinent records to our office prior to this initial visit. Thank you and we look forward to meeting you.

I. Patient Information

Today's Date: _____

Patient's Full Name:_____ DOB:____/____/_____ AGE:_____ ☐ Male ☐ Female

Address:_____City:_____State:_____Zip Code:_____

Home Phone: _____Work/Cell Phone: _____Medical Dr: _____Phone #:_____

Marital Status: ☐Married ☐ Single ☐ Widowed ☐Divorced E-Mail:_____

Medical Insurance Co.: _____ID #:_____Grp #:_____

Name of Policy Holder: _____Co-pay for In-Network Office:regular $_____/specialist $_____

Policyholder's Place of Employment: _____Policyholder's Job Titile: _____

Policyholder's Birthdate: ___/___/____Yearly deductible met? Y/N If Medicare, name of supplemental:_____

HSA insurance acct? _____ High Deductible ($1000 or more)? Referred by_____

II. Major Concerns/Chief Complaint

Please describe the reason for this evaluation (what happened, when, symptoms, current complaints; if a stroke, please describe where/type)?

_____

_____

_____

Have you noted any of the following? Please check (✓) all areas of concern.

1. Difficulty reading ☐	10. One eye turns in/out/up/down ☐	19. Poor judgment of space ☐
2. Difficulty writing ☐	11. Lid droop ☐	20. Poor fine motor coordination ☐
3. Blurred vision (far) ☐	12. Reddened eyes or lids ☐	21. Loss of use right/left hand ☐
4. Blurred vision (near) ☐	13. Light Sensitivity ☐	22. Loss of use right/ left leg ☐
5. Eye strain/Fatigue ☐	14. Squinting, closing one eye ☐	23. Poor motor planning ☐
6. Frequent eye rubbing/blinking ☐	15. Loses place when reading ☐	24. Poor short/long term memory ☐
7. Loss of vision to one side ☐	16. Tunnel vision ☐	25. Short attention span/distractible ☐
8. Headaches ☐	17. Dizziness ☐	Other:_____
9. Double vision at distance/near ☐	18. Motion/car sickness ☐	_____

Please use the following scale to rate each symptom: None Mild Moderate Severe

0 1 2 3 4 5 6

___ Headache	___ Dizziness	___ Sleeping more than usual	___ Attention difficulty	___ Motion sensitivity
___ Nausea	___ Lightheadedness	___ Sleeping less than usual	___ Feeling slowed down	___ Ruminating thoughts
___ Vomiting	___ Balance problems	___ Drowsiness	___ Sadness/hopelessness	___ Difficulty in Math
___ Sensitivity to light	___ Numbness/tingling	___ Difficulty concentrating	___ Nervous/anxious	___ Difficulty reading
___ Sensitivity to noise	___ Fatigue	___ Feeling mentally foggy	___ Irritability	___ Symptoms worse
___ Visual Problems	___ Trouble falling asleep	___ Difficulty remembering	___ More emotional	at end of day

Any other noted symptoms/problems. Please list and include onset/frequency.

_____

_____

Please comment on any long-term problems experienced prior to the problem noted on the first page: _____

_____

III. DIZZY History (please SKIP to section IV if no symptoms of dizzy)

Do you experience a false sense of motion that you are moving? ☐Yes ☐No If yes, in which direction:_____

Do you experience a false sense of motion that the world is moving? ☐Yes ☐No If yes, in which direction:_____

Are your dizziness symptoms ☐ Recent (1st episode) ☐ Reoccurring ☐ Chronic

What is the typical duration of your symptoms? ☐ Secs ☐ Several secs to a few mins ☐ Mins to one hour ☐ Days ☐ Weeks

Do you have hearing loss? ☐Yes ☐No

Do you have ringing in your ears? ☐Yes ☐No

Is there any correlation with timing of your symptoms and taking a new medication? ☐Yes ☐No ☐Maybe

Is there any correlation with timing of your symptoms and exposure to any environmental chemicals or toxins? ☐Yes ☐No

Can your symptoms of dizziness be reduced by visually fixating on a target? ☐Yes ☐No

Are there any other symptoms you experience besides dizziness? ☐Yes ☐No What? (ex. Nausea, anxiety, racing heart, etc.)

_____

Is there anything that can aggravate your dizziness? ☐Yes ☐No What?_____

Does anything help your symptoms? ☐Yes ☐No What?_____

Do any of the following movements cause you to feel disoriented or dizzy?

- Turning to the right? ☐Yes ☐No
- Turning to the left? ☐Yes ☐No
- Suddenly stopping in a car or a plane landing ☐Yes ☐No
- Moving side to side? ☐Yes ☐No
- Suddenly moving up or down on an elevator? ☐Yes ☐No
- Suddenly stopping in a car or a plane landing ☐Yes ☐No

Did your dizziness start after trauma to your ear by sudden changes of pressure to your ear? ☐Yes ☐No

Did your dizziness start after heavy weight bearing or excessive straining with bowel movements? ☐Yes ☐No

Can sneezing, straining or changes of pressure trigger your dizziness? ☐Yes ☐No

Can putting your head down to one side trigger your dizziness? ☐Yes ☐No

Can loud noises or sounds at times trigger your dizziness? ☐Yes ☐No

Have you started to notice your own voice much louder than before? ☐Yes ☐No

Have you noticed any distortions of sensations of sound? ☐Yes ☐No

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Can positional changes such as turning over in bed, bending over and then straightening up or tilting your head trigger your symptoms? ☐Yes ☐No

Are your symptoms or dizziness prompted by eye or head movements and then decrease in less than one minute? ☐Yes ☐No

Does your dizziness become less noticeable each time you repeat the same movement? ☐Yes ☐No

Do your episodes of dizziness come in sudden and brief spells? ☐Yes ☐No

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Did your dizziness come on suddenly? ☐Yes ☐No

Did your dizziness start after a recent viral or bacterial infection? ☐Yes ☐No

Do you have a history of herpes zoster outbreaks? ☐Yes ☐No

Did your dizziness start during a period of exhaustion or weakened immune system? ☐Yes ☐No

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Do you notice a feeling of fullness in the air or on the side of your head accompanying your episodes of dizziness? ☐Yes ☐No

Do you have episodes of ringing in your ear accompanying your episodes of dizziness? ☐Yes ☐No

Have you experienced two or more episodes of vertigo lasting at least 20 minutes each? ☐Yes ☐No

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Do you experience flickering light spots (visual aura) before your episodes of dizziness or headaches? ☐Yes ☐No

Do you experience a throbbing headache before or after your episodes of dizziness? ☐Yes ☐No

Do you become extremely sensitive to light and sound before or after your episodes of dizziness? ☐Yes ☐No

Have you noticed our your episodes of dizziness can be provoked by stress, low blood sugar levels, diet, chocolate, red wine, caffeine, cheeses or MSG? ☐Yes ☐No

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Have you ever been diagnosed or suffered from any of the following conditions (please check all that apply)?

☐Benign paroxysmal positional vertigo ☐Meniere's disease ☐Otoxicity ☐Otosclerosis ☐Tinnitus

☐Superior canal dehiscence ☐Acoustic neuroma ☐Stroke ☐Migraine ☐Hearing Loss

☐Transient ischemic attack ☐Peri lymphatic fistula ☐Vestibulopathy ☐Cerebellum disease ☐Neurotoxicity

☐Autoimmune inner ear disease ☐Cervicogenic syndrome ☐Cholesteatoma ☐Mal de Barquement ☐Concussion

☐Vestibular neuronitis or labyrinthitis ☐Endolymphatic hydrops ☐Trauma to ear ☐Trauma to head/brain

☐Enlarged vestibular aqueduct

IV. Vision History

Has there been previous vision care? YES ☐ NO ☐ If yes, date of last exam:_____

Name of Eye Doctor: _____(Please have these records faxed to our office).

Do you have glasses now? YES ☐ NO ☐ Do you wear them? YES ☐ NO ☐

If yes, when should you wear them?_____

Do you wear contact lenses now or previously? YES ☐ NO ☐ If yes, brand and powers:_____

How do you wear your contact lenses (please circle all that apply): daily wear / extended wear / non-disposable / disposable

Do you have any of the following eye conditions? (Please check (✓) all areas that apply)

Glaucoma ☐ Blindness ☐ Amblyopia/lazy eye ☐

Strabismus/crossed eye ☐ Cataracts ☐ Macular Degeneration ☐

Other:_____

Is there a family history of any of the following eye conditions? (Please check (✓) all areas that apply)

Glaucoma	☐	Blindness	☐	Amblyopia/lazy eye	☐
Strabismus/crossed eye	☐	Cataracts	☐	Macular Degeneration	☐

Other:_____

List all eye medications you take:_____

_____

V. Speech/Auditory History

	YES	NO		YES	NO
Is your speech clear?	☐	☐	Do you omit parts of words when speaking?	☐	☐
Can you express thoughts clearly?	☐	☐	Is speech understandable by others?	☐	☐

VI. Medical History

Date of most recent physical:_____ By Whom:_____

Results and recommendations:_____

Is there any history of the following? (Please check (✓) all areas that apply)

Diabetes	☐	Thyroid disease	☐	Musculoskeletal (muscles/bones/joints)	☐
Hypertension	☐	GI Disease	☐	Ear/Nose/Throat/Mouth	☐
Heart Disease	☐	Arthritis	☐	Mental (depression/anxiety)	☐
Lung	☐	Kidney/Bladder/Genital	☐	Integument (skin)	☐
Emphysema	☐	Neurological	☐	Allergic/Immunologic	☐
Asthma	☐	Blood/lymphatic	☐	Other: _____	

Is there any family history of medical problems? (please list) _____

Please list all medication currently used (include for what conditions): _____

_____

_____

_____

_____

VI. Surgical History

Please list all previous surgeries and dates:_____

_____

VII. Social History

	YES	NO			YES	NO	
Tobacco use	☐	☐	Packs/day:_____	Narcotic use	☐	☐	
Alcohol use	☐	☐	Drinks/day:_____	Sexually transmitted Disease	☐	☐	_____

VIII. Current Treatment (eg. Physical Therapy, Occupational Therapy, Speech Therapy, etc.)

By whom_____

Facility Name_____

Address_____

Reason? _____

Type of Treatment_____

Dates of Treatment_____

Case Manager_____Phone #:_____

X. Goals

Please list what the goals are for coming to our office:_____

_____

X. Additional Information

Do you live alone? YES ☐ NO ☐

If not, name and relationship of person who lives with you:_____Relationship_____

Do you have an employed in-home "caretaker? YES ☐ NO ☐ Caretaker's Name:_____

Who will accompany you to my office?_____

XI. Occupation

Please record occupation _____

Name/Address of Employment Place_____

City_____State_____Zip Code_____

Please list job duties_____

Are you currently working: YES ☐ NO ☐

Do you feel you are able to work: YES ☐ NO ☐ Please state why or why not:_____

_____

Have you applied or are you planning to apply for disability? YES ☐ NO ☐

XII. COMPUTER

Do you have a computer: YES ☐ NO ☐ (if yes, please continue to answer all questions in the computer section)

Do you have internet access: YES ☐ NO ☐

How many hours do you spend in front of a computer screen each day?_____

How do your eyes feel after working on the computer?_____

Where is the top of the screen located (please circle): above your straight-ahead eye level / at eye level / below eye level

What is the distance from: Your eyes to the screen?_____

Your eyes to the keyboard?_____

Your eyes to your source document?_____

Where is the computer screen located (please circle):

directly in front of you when seated / to your right / to your left / flat (horizontal) / vertical

Do you experience any of the following at work (please circle)? Glare / reflections / difficulty reading source documents

Do you use a wheelchair? YES ☐ NO ☐ Can you sit in an examination chair? YES ☐ NO ☐

XIII. Insurance Filing and Release of Information

Dr. Mackowsky uses photos and videos during her examination to evaluate posture/balance/visual spatial awareness. Your signature below gives her permission to photograph and video tape (to be used exclusively in the office) to determine the best treatment modality for the below patient.

We will file all in-network insurance claims and will provide invoices for you to file out-of-network claims. Your signature below signifies you realize you will be responsible for all copays/deductibles/non-covered services on the date the service is rendered, if you are in-network.

It is also often beneficial for us to discuss examination results and to exchange information with other professionals involved in your care. Your signature below permits information from, or copies of, your examination records to be forwarded to other health care providers or insurance carriers upon their written request or upon the recommendation of Dr. Mackowsky when it is necessary for the treatment of your visual condition, or for the processing of insurance claims. I authorize Dr. Mackowsky to exchange information with other professionals involved in my or my child's care, by means of my signature below. This authorization shall be considered valid throughout the duration of treatment.

Patient or Representative Signature _____Date _____

Relationship to Patient (if applicable):_____

Please be on time for your appointment to allow Dr. Mackowsky the full hour for her evaluation. Late arrivals will be rescheduled. We also request a minimum of 48 hours notification to reschedule an existing appointment. Thank you.

Dr. Mackowsky's Signature _____Date _____