Nancy M. Mackowsky, OD, PA

The Mackowsky
Visual Learning &
Rehabilitation Clinic

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Infant/Toddler 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. Infant's Information

Today's Date: _____

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

Parent's Names:_____ Home Phone: _____ Work/Cell Phone: _____

Address:_____City:_____State:_____Zip Code:_____

E-Mail:_____ School: _____ Grade:_____

Medical Dr: _____ Phone #:_____ Medical Insurance Co.: _____

Name of Policy Holder: _____ ID #:_____ Grp #:_____

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**

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

II. Major Concerns/Chief Complaint

Please describe the reason for this evaluation (ie, what type of problem is noted, who first noted the vision problem, when, frequency, etc.)

_____

_____

_____

Did the problem occur suddenly (please detail)?

_____

Do your child's problems seem to be related to illness, accident, or other trauma?

_____

_____

Have you noticed any differences in this child as compared to siblings or other children?

_____

_____

Does your child like to be read to? ☐ Yes ☐ No

Motor Control:

Which hand does your child prefer to use for eating? ❑ Left ❑ Right Always? ❑ Yes ❑ No ❑ Not applicable

Does your child have an awkward gait? ❑ Yes ❑ No ❑ Not applicable

Is your child exceptionally clumsy? ❑ Yes ❑ No ❑ Not applicable

III. Pregnancy and Delivery History

During Pregnancy	Yes	No		Yes	No
Hemorrhage	❑	❑	Adequate and regular nutrition during pregnancy?	❑	❑
Use of internal medications during pregnancy If yes, what?_____	❑	❑	Toxemia (blood poisoning)	❑	❑
Excessive smoking?	❑	❑	Major illness or trauma	❑	❑
Excessive alcohol?	❑	❑	Other abnormalities	❑	❑
Labor- spontaneous with no complications?	❑	❑	If yes, what?_____		

Labor and Delivery

Length of Pregnancy_____ Birth Weight_____lbs. _____oz. Length _____in.

	Yes	No		Yes	No
Blood exchange transfusion	❑	❑	Severe jaundice	❑	❑
Anoxia (lack of oxygen)	❑	❑	Resuscitation	❑	❑
Incubator	❑	❑	Seizures	❑	❑
Poor sucking	❑	❑	Abnormal cry	❑	❑
Cord around neck	❑	❑	Other, specify?_____		

IV. Infant/Toddler's Medical History

Illnesses:	Yes	No	Age		Yes	No	Age
Head trauma	❑	❑	_____	Serious infection or injury	❑	❑	_____
Convulsions or seizures	❑	❑	_____	Reactions to drugs, vaccine allergies	❑	❑	_____
Diabetic	❑	❑	_____	Allergies- specify?_____	❑	❑	_____
Encephalitis	❑	❑	_____	Severe ear infections	❑	❑	_____
Rheumatic fever	❑	❑	_____	Hospitalization-	❑	❑	_____
Asthma	❑	❑	_____	specify?_____			
Measles (severe)	❑	❑	_____	Frequent respiratory infections	❑	❑	_____
High fever	❑	❑	_____	Other?_____			

Is your child receiving any medication at this time? ❑ Yes ❑ No If yes, list name and purpose?

_____

_____

_____

V. Developmental History

Gross Motor History:

Were there any problems with the following:		Yes	No	Explain
Neck control development	4 mo.	☐	☐	_____
Sitting alone	8 mo.	☐	☐	_____
Crawling alone	9 mo.	☐	☐	_____
Stand alone	15 mo.	☐	☐	_____
Walk alone	15 mo.	☐	☐	_____

Speech-Auditory History:

	Norm	Early	Average	Slow	
Da-da, etc.	9 mo.	☐	☐	☐	_____
2 words	12 mo.	☐	☐	☐	_____
4 words	15 mo.	☐	☐	☐	_____
Short sentences	24 mo.	☐	☐	☐	_____
Gives full name	30 mo.	☐	☐	☐	_____

Does your child reply appropriately to simple directions and questions? ☐ Yes ☐ No

Does your child have to look at you to understand what you say? ☐ Yes ☐ No

Vision History:

Have you noticed your child:	Yes	Sometimes	No	When and how often do these symptoms occur?
Avoiding bright lights	☐	☐	☐	_____
Rubbing eye frequently	☐	☐	☐	_____
Developing sties	☐	☐	☐	_____
Blinking excessively	☐	☐	☐	_____
Having red eyes	☐	☐	☐	_____
Sitting too close to the TV	☐	☐	☐	_____
Other_____	☐	☐	☐	_____

VI. Previous Evaluations

Vision- for what reason?_____

By whom_____Date_____

Address_____

Neurological- for what reason?_____

By whom_____Date_____

Address_____

Other- for what reason?_____

By whom_____Date_____

Address_____

Please request copies of all previous evaluations/reports be sent to us prior to exam date to complete our history of your child.

VII. Family Medical History

Family history to three generations. If yes, please specify relationship.

	Yes	No	Relationship		Yes	No	Relationship
Multiple births	☐	☐	_____	Vision Problems	☐	☐	_____
Hereditary diseases	☐	☐	_____	Auditory Problems	☐	☐	_____
Neuropsychiatric disorders	☐	☐	_____	Diabetic	☐	☐	_____
Speech difficulty	☐	☐	_____	Epileptic	☐	☐	_____
Reading and writing difficulties	☐	☐	_____	Asthmatic	☐	☐	_____
Hyperactivity	☐	☐	_____				

VIII. Goals

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

_____

IX. Parent or Guardian Information (if different from front page)

Father's/Mother's (or Guardian) name_____

Street address (if different from child's)_____

City_____ State_____ Zip_____

Home phone_____ Cell phone_____Work phone_____

E-mail_____ Occupation or position_____

Do you have a computer: YES ☐ NO ☐ Do you have internet access: 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 Parent 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 _____