

Medical Questionnaire Review

Chart # _____

Name of Patient: _____ Exam Date: _____
Date of Birth: ____ / ____ / ____ Grade level (if applicable): _____
Name of person completing this form: _____

Please let us know if there have been any changes with patient's demographic information since your last visit.
(please check if no changes)

1) Reason for visit (please list goals).

2) Please list any significant changes in function since your last evaluation with Dr. Mackowsky.

3) 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

4) Please list any changes in your general health since your last visit.

5) Please list all current medications and dosages. (please check if no changes)

6) Have there been any illnesses /injuries, operations or hospitalizations since your last visit. Yes No (If yes, please list details)

7) List any additional concerns you need to share with Dr. Mackowsky today. _____

Signature (please circle: patient/parent/spouse/caretaker) _____

Date _____

Dr. Mackowsky's Signature _____

Date _____