The Mackowsky Visual Learning & Rehabilitation Clinic

Nancy M. Mackowsky, OD, PA

Blue Ridge Plaza, 4505 Fair Meadow Lane, Suite 207, Raleigh, NC 27607

Telephone: (919) 787-7600 | Fax: (919) 787-7603 | Victoria.Martino@DrMackowsky.com

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 (MM / DD / YYYY)	Patient's Full Name			DOB (MM / DD / YYYY)
AGE	Male / Female ☐ Male ☐ Female	Parent's Names		
Home Phone	Work/Cell Phone	E-Mail		
Address	City	State	Zip Code	
School			Grade	
Medical Dr	Phone #	Medical Insurance Co.		
Name of Policy Holder	ID #	Grp #		
Co-pay for In-Network Office: regular $	Co-pay for In-Network Office: specialist $	Policyholder's Place of Employment		
Policyholder's Job Title	Policyholder's Birthdate (MM / DD / YYYY)	Yearly deductible met? ☐ Yes ☐ No		
HSA insurance acct? ☐ Yes ☐ No	High Deductible ($1000 or more)? ☐ Yes ☐ No	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?

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 If yes, what? _____	☐	☐
Labor- spontaneous with no complications?	☐	☐			

Labor and Delivery

Length of Pregnancy	Birth Weight (lbs.)	Birth Weight (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	☐	☐	

	Yes	No	Age		Yes	No	Age
Diabetic	☐	☐		Allergies Specify? _____	☐	☐	
Encephalitis	☐	☐		Severe ear infections	☐	☐	
Rheumatic fever	☐	☐		Hospitalization Specify? _____	☐	☐	
Asthma	☐	☐		Frequent respiratory infections	☐	☐	
Measles (severe)	☐	☐					
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:

Milestone		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	☐	☐	☐	

Have you noticed your child:	Yes	Sometimes	No	When and how often do these symptoms occur?
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		Yes	No
Multiple births Relationship: _____	☐	☐	Vision Problems Relationship: _____	☐	☐
Hereditary diseases Relationship: _____	☐	☐	Auditory Problems Relationship: _____	☐	☐
Neuropsychiatric disorders Relationship: _____	☐	☐	Diabetes Relationship: _____	☐	☐
Speech difficulty Relationship: _____	☐	☐	Epileptic Relationship: _____	☐	☐
Reading and writing difficulties Relationship: _____	☐	☐	Asthma Relationship: _____	☐	☐
Hyperactivity/Attend difficulties Relationship: _____	☐	☐			

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

X. 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 _____