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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, recovery, and current complaints)?

_____

_____

_____

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 ❒	_____

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. 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:_____

IV. Speech/Auditory History

Is your speech clear? YES ☐ NO ☐ Do you omit parts of words when speaking? YES ☐ NO ☐

Can you express thoughts clearly? YES ☐ NO ☐ Is speech understandable by others? YES ☐ NO ☐

V. Medical History

Date of most recent physical:_____ By Whom:_____

Results and recommendations:_____

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

_____

_____

_____

_____

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) _____

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 #:_____

IX. 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

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 _____