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. Familv Medical Historv

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

	Yes	No	Relationship
Multiple births	☐	☐	___________
Hereditary diseases	☐	☐	___________
Neuropsychiatric disorders	☐	☐	___________
Speech difficulty	☐	☐	___________
Reading and writing difficulties	☐	☐	___________
Hyperactivity	☐	☐	___________

	Yes	No	Relationship
Vision Problems	☐	☐	___________
Auditory Problems	☐	☐	___________
Diabetic	☐	☐	___________
Epileptic	☐	☐	___________
Asthmatic	☐	☐	___________

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

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 ________________