Nancy M. Mackowsky, O.D., F.C.O.V.D.
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Medical Questionnaire Review

Chart # _____

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

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