

# Pittsburgh Oculoplastic Associates, Ltd.

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**PLEASE COMPLETE THE FOLLOWING QUESTIONNAIRE AND BRING IT TO YOUR APPOINTMENT.**

NAME: \_\_\_\_\_  
ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
DATE OF BIRTH: \_\_\_\_\_ AGE: \_\_\_\_\_

DATE: \_\_\_\_\_  
HOME PHONE: (\_\_\_\_) \_\_\_\_\_  
WORK PHONE: (\_\_\_\_) \_\_\_\_\_  
CELL PHONE: (\_\_\_\_) \_\_\_\_\_  
SEX: Male \_\_\_ Female \_\_\_

WHAT IS THE REASON YOU ARE COMING TO SEE US? (what kind of problem, when did it start, what treatments have you already received, etc.) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY:                      PLEASE CIRCLE PERTINENT RESPONSES                      DATES / EXPLAIN**

How would you rate your overall health?                      Poor    Fair    Good    Excellent

Do you have now or have ever had:

- |     |   |    |     |       |
|-----|---|----|-----|-------|
|     |   | No | Yes |       |
| 1.  | Fevers, chills, night sweats, unexplained fatigue?      |    |     | _____ |
| 2.  | Have you gained or lost more than 10 pounds last year?  |    |     | _____ |
| 3.  | Ear, nose, throat problems?                             |    |     | _____ |
|     | loss of hearing, smell, sinus disease?                  |    |     | _____ |
|     | Vertigo, dry mouth, difficulty swallowing?              |    |     | _____ |
| 4.  | Heart or circulation problems?                          |    |     | _____ |
|     | Heart attack, angina?                                   |    |     | _____ |
|     | Congestive heart failure, shortness of breath?          |    |     | _____ |
|     | Irregular or rapid heart beat?                          |    |     | _____ |
|     | Cardiac pacemaker or heart valve?                       |    |     | _____ |
|     | High blood pressure?                                    |    |     | _____ |
| 5.  | Lung problems?  |    |     | _____ |
|     | Asthma?   |    |     | _____ |
|     | Chronic cough, emphysema, bronchitis?                   |    |     | _____ |
|     | Tuberculosis?   |    |     | _____ |
| 6.  | Gastrointestinal problems?                              |    |     | _____ |
|     | Ulcers, gastritis, colitis, frequent diarrhea?          |    |     | _____ |
|     | Liver disease, hepatitis (type ___)?                    |    |     | _____ |
| 7.  | Genitourinary, kidney, bladder, prostate problems?      |    |     | _____ |
|     | Stones, infections, frequency?                          |    |     | _____ |
| 8.  | Muscle, weakness, inflammation, fatigue?                |    |     | _____ |
|     | Arthritis, rheumatoid, gout?                            |    |     | _____ |
| 9.  | Skin, nail, hair problems; eczema, psoriasis, rosacea?  |    |     | _____ |
|     | Skin cancer?  |    |     | _____ |
| 10. | Nervous system?   |    |     | _____ |
|     | TIA, strokes, seizures, tremor?                         |    |     | _____ |
|     | Headaches?  |    |     | _____ |
|     | Memory loss, disorientation?                            |    |     | _____ |
|     | Depression, anxiety, nervous breakdown?                 |    |     | _____ |
| 11. | Blood Disorders, anemia, clots in legs?                 |    |     | _____ |
|     | Easy bruising, bleeding, transfusion of blood products? |    |     | _____ |
| 12. | Diabetes?   |    |     | _____ |
|     | Date of onset / Duration _____                          |    |     |       |
|     | Treatment:   Diet   oral agents   insulin _____         |    |     |       |
| 13. | Thyroid disease: overactive or underactive?             |    |     | _____ |
|     | Treatment?  |    |     | _____ |
| 14. | HIV positive test, AIDS?                                |    |     | _____ |
| 15. | Cancer or Tumor?  |    |     | _____ |
|     | Type of treatment?                                      |    |     | _____ |
| 16. | Other medical problems?                                 |    |     | _____ |

**SURGERY:** LIST TYPE OF OPERATION and DATES

Eye or eyelid surgery: \_\_\_\_\_

Other Surgeries (Including cosmetic): \_\_\_\_\_

Any problems with anesthesia? \_\_\_\_\_

**CURRENT MEDICATIONS:** (Give names, dosage, and frequency)

Eye Medications: _____	Prescription Medications: _____	Non-prescription Medications: _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

When did you last take aspirin or an aspirin-containing product? \_\_\_\_\_

**ALLERGIES:** Medications, foods, chemicals, environment. (Please describe reaction and when it occurred)

\_\_\_\_\_

**SOCIAL HISTORY:**

- Are you a smoker? Yes \_\_\_ No \_\_\_ Did you ever smoke? Yes \_\_\_ No \_\_\_
- If yes, how many cigarettes per day? \_\_\_\_\_ When did you stop? \_\_\_\_\_
- Do you drink alcohol? Yes \_\_\_ No \_\_\_ \_\_\_\_\_ drinks per day \_\_\_\_\_ drinks per week
- Marital Status: Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Widowed \_\_\_ Other \_\_\_
- Current occupation: \_\_\_\_\_ If retired, prior occupation: \_\_\_\_\_
- Are there any social problems affecting your health (family illness, deaths, stress, etc.)? \_\_\_\_\_

**FAMILY HISTORY:** Among your blood relatives, is there a history of the following: EXPLAIN:

1. Glaucoma	No	Yes	_____
2. "Lazy eye" or muscle imbalance	No	Yes	_____
3. Droopy eyelid	No	Yes	_____
4. High Blood Pressure	No	Yes	_____
5. Diabetes	No	Yes	_____
6. Thyroid Disease	No	Yes	_____
7. Bleeding Disorders	No	Yes	_____
8. Problems with Anesthesia	No	Yes	_____

Please give the name and address of the **doctor who referred you** to us:

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

your **primary medical** doctor:

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

any other doctors who you are currently seeing:

\_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

**Primary Pharmacy (required)**

Address \_\_\_\_\_

\_\_\_\_\_

Telephone \_\_\_\_\_

The information above is accurate to the best of my knowledge.

Patient's Signature \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_