Pittsburgh Oculoplastic Associates, Ltd.

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

NAME: _____ DATE: _____
ADDRESS: _____ HOME PHONE: _(_____)_____
_____ CELL PHONE: _(_____)_____
_____
DATE OF BIRTH: _____ AGE: _____ 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:

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

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:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take aspirin on a regular basis? ___ No ___ Yes If Yes, please list dosage and frequency _____

ALLERGIES: Medications, foods, chemicals, environment. Latex allergy? Yes ____ No ____

_____

_____

OCULAR HISTORY: Do you currently have or have ever had:

1. Glaucoma?	No	Yes	_____
2. Cataracts?	No	Yes	_____
3. Cataract Surgery?	No	Yes	_____
4. Macular Degeneration?	No	Yes	_____
5. Currently wearing eyeglasses?	No	Yes	_____
6. Currently wearing contacts?	No	Yes	_____
7. Dry eyes?	No	Yes	_____
8. Ocular trauma?	No	Yes	_____
9. Previous Eyelid surgery?	No	Yes	_____

SOCIAL HISTORY:

1. Are you a smoker? Yes ____ No ____ If yes, ____ packs/day Did you ever smoke? Yes ____ No ____
2. Smokeless tobacco use? Yes ____ No ____ Illegal drug use? Yes ____ No ____
3. Do you drink alcohol? Yes ____ No ____ ___ drinks per day ____ drinks per week
4. Marital Status: Single ___ Married ___ Divorced ___ Widowed ___ Other ___
5. Current occupation:_____ If retired, prior occupation: _____

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

1.	Adverse reaction to anesthesia	No	Yes	_____
2.	Cancer	No	Yes	_____
3.	Diabetes	No	Yes	_____
4.	Glaucoma	No	Yes	_____
5.	Heart Disease	No	Yes	_____
6.	High Blood Pressure	No	Yes	_____
7.	Thyroid Disease	No	Yes	_____

Please give the name and address of

The **doctor who referred you** to us:

_____

_____

_____

Telephone _____

Your **primary medical** doctor:

_____

_____

_____

Telephone _____

Pharmacy Name and Phone Number: _____

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

Patient's Signature_____ Reviewed by: _____ Date: _____

PITTBURGH OCULOPLASTIC ASSOCIATES, Ltd.

Acct # _____

PATIENT INFORMATION

Patient Name: _____ Marital Status: _____
Social Security Number: _____ Driver's License No: _____
Employer: _____ Employer's Phone No: _____
Employer's Address: _____ Retired? _____

Person to Contact in Case of Emergency: _____ Phone: ( ) _____
Address: _____Relation to You: _____

GUARANTOR INFORMATION (Person responsible for Payment of Account)

Guarantor Name: _____ Guarantor's Phone: ( )_____
Address: _____ Guarantor's Employer: _____
_____ Guarantor's Social Security #: _____
Guarantor's Date of Birth: _____

INSURANCE INFORMATION

Primary
Name of Insurance Company: _____
Name of Policy Holder: _____ Relationship to Patient: _____
ID # _____ Group # _____ Date of Birth _____
Employer: _____

Secondary
Name of Insurance Company: _____
Name of Policy Holder: _____ Relationship to Patient: _____
ID # _____ Group # _____ Date of Birth _____
Employer: _____

Other
Medical Assistance Program Recipient ID# _____ Card Issue # _____
Worker's Compensation/Auto Accident/Trauma (Circle and Complete on Reverse Side)

ASSIGNMENT OF BENEFITS: I hereby assign all medical and/or surgical benefits to which I am entitled including major medical, Medicare, private insurance and any other health plans to Pittsburgh Oculoplastic Associates. Ltd. This agreement will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize release of any information needed to determine these benefits payable for related services. I am financially responsible for the deductible co-insurance, and non-covered services. Co-payments and non-covered services are to be paid at the time services are rendered. I understand that I am to forward any payment that I may receive from my insurance carrier for services rendered. I have read and understand the payment policy of Pittsburgh Oculoplastic Associates.

Signature of Patient/Guarantor: _____ Date: _____

Signed by Policy Holder (If other than patient) _____

ACCIDENT CLAIM INFORMATION

Date of Accident: _____

Type of Accident (Circle One): Worker's Compensation Automobile Other

Claim Number: _____

Insured Party: _____

Name of Insurance Company: _____

Claim Address: _____

_____

Phone: ( ) _____

Name of Claim Representative: _____

Policy Limit Amount: _____