

Pittsburgh Oculoplastic Associates, Ltd.

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

NAME: _____
 ADDRESS: _____

DATE: _____
 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:

- | | | Poor | Fair | Good | Excellent | |
|-----|---------------------------------------------------------|------|------|------|-----------|-------|
| 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: _____