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?	No	Yes	______
11.	**Blood Disorders, anemia, clots in legs?**	**No**	**Yes**	______
	Easy bruising, bleeding, transfusion of blood products?	No	Yes	______
12.	**Diabetes?**	**No**	**Yes**	______
	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 received a Covid-19 vaccination?	No	Yes	______
21.	**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: ______________________________