# Pittsburgh Oculoplastic Associates, Ltd.

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

NAME: _____ DATE: _____
ADDRESS: _____ HOME PHONE: _(_____)_____
_____ CELL PHONE: _(_____)_____
_____ GENDER: Male _____ Female _____
DATE OF BIRTH: _____ AGE: _____ HEIGHT: _____ WEIGHT: _____

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 | _____ |
| 11. | Depression or Anxiety? | No | Yes | _____ |
| 12. | Blood Disorders, anemia, clots in legs? | No | Yes | _____ |
| | Easy bruising, bleeding, transfusion of blood products? | No | Yes | _____ |
| 13. | Diabetes? | No | Yes | _____ |
| | Treatment: Diet__ oral agents__ insulin__ | | | |
| 14. | Thyroid disease: overactive or underactive? | No | Yes | _____ |
| | Treatment? | No | Yes | _____ |
| 15. | HIV positive test, AIDS? | No | Yes | _____ |
| 16. | Cancer or Tumor? | No | Yes | _____ |
| | Type of treatment? | No | Yes | _____ |
| 17. | Sleep Apnea? | No | Yes | _____ |
| 18. | Other medical problems? | No | Yes | _____ |
| 19. | Have you received a vaccination for pneumonia? | No | Yes | _____ |
| 20. | Have you received a vaccination for influenza (flu)? | No | Yes | _____ |
| 21. | Have you received a Covid-19 vaccination? | No | Yes | _____ |
| 22. | 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: _____