Pittsburgh Oculoplastic Associates, Ltd.

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

NAME: _____ DATE: _____
ADDRESS: _____ HOME PHONE: _(_____)_____
_____ WORK 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?	No Yes	
Chronic cough, emphysema, bronchitis?	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. Other medical problems?	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:

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

ALLERGIES: Medications, foods, chemicals, environment. Latex allergy? ____ YES _____ NO

_____

_____

SOCIAL HISTORY:

1. Are you a smoker? Yes ____ No ____ Did you ever smoke? Yes ____ No ____
2. If yes, how many cigarettes per day? _____ When did you stop? _____
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: _____
6. 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: _____