PROVIDING COMPREHENSIVE MEDICAL AND SURGICAL CARE OF THE MACULA, RETINA AND VITREOUS TO THE CSRA

Southeast Retina Center, P.C. Augusta Retina-Laser Surgicare

Tel (706) 650-0061 • Fax (706) 650-0064 Tel (706) 210-0305 • Fax (706) 210-0306
3685 Wheeler Road • Suite 201 - 202
Augusta, Georgia 30909-6440

Dennis M. Marcus, M.D.
Preeti Rebecca Poley, M.D., MPH

PLEASE FILL OUT ALL PAGES

Patient Name:_ _____ Date of Birth: _____

Family/Primary Doctor/Internist: Eye Doctor: _____

List ALL medical problems:

_____
_____
_____
_____
_____

List ALL prescribed medications with dosage:

_____
_____
_____
_____
_____
_____

Have you received a Pneumonia Vaccination? □YES □NO If YES, date of vaccination:

_____

Have you received a Flu Vaccination? □YES □NO If YES, date of vaccination: _____

LIST ALL EYE DROPS

_____
_____
_____
_____
_____

Do you have any ALLERGIES to medications or eye drops? □YES □NO

If YES, list the medications and/or eye drops:

_____
_____
_____
_____

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PAST EYE HISTORY

MARK ALL THAT APPLY

□CATARACT □DISTORTION □EYE INJURY/TRAUMA □FLASHING/ LIGHTS □FLOATERS □GLAUCOMA

□GLARE □LAZY EYE □RETINAL DETACHMENT □NONE

Please list any other eye problems:

_____
_____
_____
_____
_____

List all EYE surgeries: ☐ NONE

_____
_____
_____
_____
_____

List all OTHER surgeries: ☐ NONE

_____
_____
_____
_____

Have you been hospitalized in the last 12 months? □YES □NO

If YES, list the reason and all dates:

_____
_____
_____

Do you have diabetes? □YES □NO

If Yes, What type do you have? □Type I (one) □Type II (two)

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If YES, How long have you been a diabetic?

_____

Is your Diabetes controlled or uncontrolled?

_____

What was your last Blood Sugar Level? _____

What was your last Hemoglobin A1C? _____

Do you use Insulin? □YES □NO

REVIEW OF SYSTEMS

Please mark the box and or circle any persistent symptoms you have had in the past 6 months.

Cardiovascular:

□High Blood pressure □Headaches □Palpitations (fast or irregular heartbeat)

□Fainting □Heart Attack □Chest Pain □No Problems

Constitutional:

□Fever □Weight loss □Fatigue □Loss of appetite □Chills □No Problems

Ear/Nose/Throat

□Hearing Loss □Sore throat/Difficulties Swallowing □Runny Nose □Dry Mouth □Dizziness □Nose Bleeds

□No Problems

Endocrine:

□Excessive Thirst □Excessive Urination □Heat/Cold intolerance □Hair Loss/Dry Skin □No Problems

Gastrointestinal:

□Abdominal Pain □Diarrhea □Nausea □Bloody Stool □Mouth Sore/Ulcers □Stomach Ulcers □Constipation

□Reflux □No Problems

Genitourinary:

□Pain/Burning on Urination □Blood in Urine □Bladder trouble □Dialysis □Genital Sores/Ulcers □Impotence □Kidney Problems □No Problems

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Hematology:

□Easy Bruising □Prolonged Bleeding □No Problems

Musculoskeletal:

□Muscle Aches □Joint Pain □Muscle Cramps □Joint Swelling □Back Pain □Difficulty lying flat

□No Problems

Neurologic

□Weakness □Scalp Tenderness □Stroke □Paralysis □Seizures or Convulsions □Numbness/Tingle in Body

□Tremors □No Problems

Respiratory:

□Wheezing □Chronic Cough □Coughing up blood □Shortness of Breath □Severe of Frequent Colds

□Difficulty Breathing □No Problems

Other systemic problems not listed above:

_____

_____

_____

_____

SOCIAL HISTORY

Smoking/Tobacco (Mark One)

□Never

□Former If you are a FORMER smoker, how long ago did you quit? _____

How much did you smoke? packs per week

□Current If CURRENTLY smoking packs per week

Alcohol: □None □1-2 per week □3-4 per week □7+ per week

Substance Abuse: □YES □NO

Occupation: _____

Previous Occupation if retired: _____

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FAMILY HISTORY: Indicate with an 'X' which blood relative has had the following diseases

******* If you are adopted, please circle Adopted *******

Disease	Mother	Father	Sister(s)	Brother(s)	Mom's Mom	Mom's Dad	Dad's Mom	Dad's Dad	Other
Adopted	I do not know my family history								
Macular Degeneration									
Blindness									
Congenital Cataract									
Glaucoma									
Retinal Detachment									
Amblyopia									
Arthritis/Rheumatism									
Cancer									
Diabetes									
Headaches/Migraines									
Hypertension									
High Cholesterol									
Kidney Diseas									
Thyroid Disease									
Stroke									

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Uveitis/Iritis									
Heart Disease									
Genetic Disorders									
Bleeding or Clotting Disorder									
Autoimmune Disease									
Asthma									

Patient Authorization for Use and Disclosures of

Protected Health Information to Third Parties

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Name of Practice: SOUTHEAST RETINA CENTER, P.C.

Section must be completed for all authorizations

I hereby authorize the use of disclosure of my individually protected health information. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations.

Patient Name: _____

ID Number: _____

Persons/Organizations Receiving Information: _____

Name:_____ Relationship:_____
Phone:_____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this authorization will expire on ____/___/_____ (**MM/DD/YYYY**) **Initials**:
_____

2. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it won't have any effect on any actions they took before they received the revocation. **Initials**:
_____

Signature of patient or representative: _____ **Date**:
_____

(Form MUST be completed before signing)

Printed name of patient's representative: _____

Relationship to patient: _____

YOU MAY REFUSE TO SIGN THIS AUTHORIZATION