



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, MD
Kunyong Xu, MD, MHSc, FRCSC, DABO

Augusta - Southeast Retina Center PC

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:



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Do you have diabetes? YES NO

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

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



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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

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 or Frequent Colds
- Difficulty Breathing No Problems

Other systemic problems not listed above:

SOCIAL HISTORY

Smoking/Tobacco (Mark One)



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**Patient Authorization for Use and Disclosures of
Protected Health Information to Third Parties**

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