

Registration Form

Date of Birth _____ Soc. Sec. No: _____

Name: _____

Address: _____

Home Phone: _____ Can messages be left: Yes _____ No _____

Sex: M _____ F _____ Marital Status: _____ Employer: _____

Work Phone: _____ Can messages be left: Yes _____ No _____

Spouse Name: _____ Spouse Date of Birth: _____

Primary Insurance: _____

Secondary Ins: _____

Referring Physician: _____

Primary Care Physician: _____

Emergency Contact: _____ Phone: _____

To whom may we release information: _____

Financially Responsible Party/ Name: _____

SSN: _____ Date of Birth: _____ Phone: _____

Address: _____

Employer: _____ Work Phone: _____

I AUTHORIZE THE DISCLOSURE OF MY PERSONAL HEALTH INFORMATION TO MY REFERRING PHYSICIAN, PRIMARY CARE PHYSICIAN, AND THE INSURANCE COMPANY, IF APPLICABLE, VIA THE USE OF WRITTEN OR FAX TRANSMITTAL, TO CARRY OUT TREATMENT, PAYMENT, OR HEALTH CARE OPERATIONS. I ACCEPT FULL FINANCIAL RESPONSIBILITY FOR THE SERVICES RENDERED AND AGREE TO PAY ALL REASONABLE COLLECTION COSTS AND ATTORNEY FEES IN THE EVENT OF DEFAULT OF PAYMENT ON CHARGES. I FURTHER AUTHORIZE AND REQUEST INSURANCE PAYMENTS BE MADE DIRECTLY TO SOUTHEASTERN RETINA ASSOCIATES SHOULD THEY ELECT TO RECEIVE SUCH PAYMENTS. I UNDERSTAND AND AGREE TO THE ABOVE CONDITIONS. SIGNATURE BELOW INDICATES AGREEMENT. MY SIGNATURE BELOW ALSO INDICATES THAT A COPY OF THE PRIVACY POLICY FOR SOUTHEASTERN RETINA ASSOCIATES HAS BEEN MADE AVAILABLE TO ME.

Signature of Patient

Date

DATE: _____

MEDICAL AND OCULAR

HISTORY QUESTIONNAIRE



SOUTHEASTERN RETINA ASSOCIATES, P.C.
Diseases and Surgery of the Retina and Vitreous

- John C. Hoskins, M.D. Joseph M. Googe, Jr., M.D.
- James H. Miller, Jr., M.D. Joseph M. Gunn, M.D.
- Tod A. McMillan, M.D. Howard L. Cummings, M.D.
- D. Allan Couch, M.D. Stephen L. Perkins, M.D.
- Nicholas G. Anderson, M.D.

Account Number: _____

Patient Name: _____ Sex: _____ Date of Birth: _____

Eye Doctor: _____ Address: _____

Medical Doctor: _____ Address: _____

Please answer the following questions to the best of your ability. Give dates, a brief description, and which eye was involved to any **yes** question.

PRESENT ILLNESS

Please describe your current eye problem. _____

OCULAR HISTORY

Have you ever had any eye disease, surgery, or injury in the past? <input type="checkbox"/> No / <input type="checkbox"/> Yes		
If yes, please describe. Include dates and the name of the doctor who treated you.		
Doctor	Date	Describe

Did any previous eye disorder result in loss of vision? No / Yes

If yes, please describe. _____

Have you ever worn glasses or contact lenses? No / Yes

How old is your current prescription? _____

Have you ever been told you have amblyopia or "lazy eye"? No / Yes

MEDICAL / SURGICAL HISTORY

Have you had any serious medical problems? No / Yes

(for example: heart, lung, kidney disease, high blood pressure, cancer or AIDS)

If yes, please describe. _____

Do you have diabetes? No / Yes

How long have you had diabetes? _____

How often do you see your diabetic doctor? _____

How often do you test your blood sugar? _____ urine sugar? _____

How high was your blood sugar when last tested? _____

Have you ever had an insulin reaction? No / Yes

Date of last reaction: _____

Patient Name: _____ Date: _____

Have you ever been hospitalized for any reason? No Yes

If yes, please describe. _____

Have you had any major surgery? No Yes

If yes, please describe. _____

Have you had any complications from anesthesia? No Yes

SOCIAL HISTORY

Educational level: High School No Yes

College No Yes

Post-Graduate No Yes

Other: _____

Present Occupation: _____

Does your vision make it difficult for you to: Read? No Yes

Write? No Yes

Drive? No Yes

Cook? No Yes

Work? No Yes

Watch TV? No Yes

Do you: Exercise less than 3 to 4 times

a week? No Yes

Wear Seat Belts? No Yes

Use drugs? No Yes

Drink alcohol? No Yes

Smoke? No Yes

Chew tobacco? No Yes

Live alone? No Yes

Have you ever had sexual contact with a person who may have been exposed to or infected with the AIDS virus? No Yes

FAMILY HISTORY

Is there any eye disease which runs in your family? No Yes
(for example: glaucoma, retinal detachment, or retinal degeneration)

If yes, please describe. _____

Has any member of your family lost vision for any reason? No Yes

If yes, please describe. _____

Is there any significant medical disease which runs in your family? No Yes
(for example: heart, lung, or kidney disease, high blood pressure or cancer)

If yes, please describe. _____

Patient Name: _____ Date: _____

REVIEW OF SYSTEMS

Have you ever had ...

CARDIOVASCULAR:

- Chest pain? No Yes
Enlarged heart? No Yes
Heart disease? No Yes
Heart murmur? No Yes
Irregular heart beat? No Yes
Shortness of breath? No Yes
Swelling of feet? No Yes
Phlebitis? No Yes
High blood pressure? No Yes

HEMATOLOGY:

- Anemia? No Yes
Bleeding disease? No Yes
HIV+? No Yes
Venereal disease? No Yes
Sickle Cell disease? No Yes
Hepatitis? No Yes
Lyme disease? No Yes

NEUROLOGY:

- Stroke? No Yes
Seizures? No Yes
Paralysis? No Yes
Dizziness? No Yes
Double vision? No Yes

GENITOURINARY:

- Kidney trouble? No Yes
Urine problem? No Yes
Gonorrhea? No Yes
Syphilis? No Yes

Other? No Yes

Describe. _____

PULMONARY:

- Asthma/emphysema? No Yes
Cough? No Yes
Coughing blood? No Yes
Lung disease? No Yes
Pleurisy? No Yes
Pneumonia? No Yes
T.B.? No Yes
Wheezing? No Yes
Bronchitis? No Yes

ENDOCRINE:

- Thyroid disease? No Yes
Diabetes? No Yes
Sarcoidosis? No Yes

PSYCHIATRY:

- Depression? No Yes
Other disorders? No Yes

GASTROENTEROLOGY:

- Stomach trouble? No Yes
Trouble with intestines? No Yes
Trouble with bowel movements? No Yes

REPRODUCTIVE:

- Are you pregnant? No Yes
Date of last menstrual period: _____

RHEUMATOLOGY:

- Trouble with your joints? No Yes
Back trouble? No Yes

Patient Name: _____ Date: _____

Do you have any drug allergies? No Yes
If Yes, Please Describe. _____

What kind of reactions have you experienced? _____

MEDICATIONS

Please list any medication(s) including **eye drops**, which you are taking. List the amount or strength of the medication(s) and how frequently you take the medication(s).

Name of Medication	Amount Taken	Times Taken	Eye

THIS SPACE RESERVED FOR PHYSICIAN ONLY

Chief Complaint/History of Present Illness: SYMPTOMS • LOCATION • QUALITY • SEVERITY • DURATION • TIMING • CONTEXT • MODIFIERS

Physician's Signature: _____ Tech. Init. _____ Date: _____

Physical Exam for Hospital Admission

Vital Signs: Pulse _____ B/P _____ Resp. _____ Temp. _____ Mental Status _____

Head & Neck Normal Other _____ Extremities Normal Other _____

Abdomen Normal Other _____ Lungs Normal Other _____

Cardiovascular Normal Other _____ Neurologic Normal Other _____

Eyes **See Admission Note**

Physician's Signature: _____ Date: _____