

PATIENT HISTORY

NAME: _____ RACE/ETHNICITY: _____
 OCCUPATION: _____ HOBBIES: _____
 PRIMARY LANGUAGE SPOKEN: _____
 TRANSLATOR REQUIRED? YES NO N/A (circle one)
 HEIGHT: _____ WEIGHT: _____

Please circle YES or NO for each question, sign your name and fill in the date at the end of the form.

- | | | |
|---|-----|----|
| 1. Do you have an irregular heartbeat or any trouble with your heart? | Yes | No |
| 2. Do you have high blood pressure? | Yes | No |
| 3. Have you ever had a stroke? | Yes | No |
| If yes, when _____ | | |
| 4. Do you have chest pains, asthma, or emphysema? | Yes | No |
| 5. Have you ever had a heart attack? | Yes | No |
| If yes, when _____ | | |
| 6. Any history of epilepsy or seizures? | Yes | No |
| 7. Have you had rheumatic fever? | Yes | No |
| 8. Are you a diabetic? | Yes | No |
| If yes, list type and amount of drug taken for diabetes | | |
| _____ | | |
| 9. Do you smoke or use tobacco? | Yes | No |
| If yes, how much? _____ | | |
| 10. Do you have multiple sclerosis? | Yes | No |
| 11. Have you had a persistent cough for over 3 weeks? | Yes | No |
| A. Is there blood in the sputum? | Yes | No |
| B. Any elevated temperature (over 100°F in the last week?) | Yes | No |
| C. Are you having night sweats? | Yes | No |
| D. Any recent unexplained weight loss? (5% in last 3 months) | Yes | No |
| E. Any known contact with TB, or have you been diagnosed with TB? | Yes | No |
| 12. Have you ever been diagnosed with cancer? | Yes | No |
| 13. Do you have false teeth, caps or contact lenses? | Yes | No |
| 14. Have you ever had jaundice or hepatitis? | Yes | No |
| 15. Have you ever been tested for HIV (AIDS)? | | |
| If yes, when and what were the results? _____ | | |
| 16. Have you ever had any problems with mental illness? | Yes | No |
| 17. Have you ever been told you are a bleeder? | Yes | No |
| 18. Do you have frequent headaches or migraines? | Yes | No |
| 19. Have you ever had a head injury or brain tumor? | Yes | No |

20. Have you ever lost consciousness? Yes No
21. Have you had Transient Ischemic Attacks (TIA)? Yes No
22. Have you ever had trouble with drugs or alcohol? Yes No
23. Have you ever had a blood transfusion? Yes No
If so, when: _____ where: _____
24. Have you ever had general anesthesia? Yes No
If so, date of the last time: _____
25. Have you ever had a reaction to local or general anesthesia? Yes No
If yes, what kind of reaction: _____
26. Please list all of the operations you have had. Give dates (Month/Year)

27. Any family history of anesthetic problems, including sudden death or malignant hyperthermia. (an unusually increased temperature after anesthesia)? Yes No

28. Have you ever had any of the following problems? If yes, please mark.
- Glaucoma Blindness Cataract Lazy eye
 Retinal Disease Crossed Eyes Macular Degeneration
 Retinitis Pegmentosa Cranial or Temporal Arteritis
 Serious Eye injury Optic Neuritis Keratoconus

29. Family History	Living	General Health	Cause of Death
Mother	Yes No	_____	_____
Father	Yes No	_____	_____
Brother(s)	Yes No	_____	_____
Sister (s)	Yes No	_____	_____

30. If you have any medical problems not covered by the above questions, please note:

31. Name of the doctor you see for regular health care: _____

DATE: _____ **SIGNATURE:** _____

PATIENT HISTORY

To be completed by staff member

Name _____ Age _____

Primary Care Physician _____

REVIEW OF SYSTEMS

	PROBLEMS		CHECK ALL THAT APPLY			
	YES	NO				
Ear, Nose, Throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Persistent cough for past 3 weeks		
Heart	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High or low blood pressure		
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Tuberculosis
G. I.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Hiatal Hernia
Skeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	Diabetes
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Neck or back pain – disc disease		


Explanation Of Any Positive Answer: _____

Signature
(Reviewed medications / allergies / above info. with Patient)

Date

Signature
(Reviewed medications / allergies / above info. with Patient)
(for second eye)

Date



John R. Wright, D.O.

The Wright Eye Center, P.C. / Natural Eyes Laser and Surgery Center
2485 E. Pikes Peak Ave.
Colorado Springs, CO 80909
719-634-2001

April 14, 2003

Dear Patient,

As a patient of The Wright Eye Center PC and / or Natural Eyes Laser and Surgery Center (WEC / NELSC), one of the responsibilities you have entrusted to us is the protection of your personal medical information. At this time, we want to make you aware of a new law governing how health care providers use and disclose medical information about you. For the first time, the Health Insurance Portability and Accountability Act of -1996 ("HIPAA") establishes a federal medical privacy and security standard.

One of the key requirements of the new law is for health care providers (your doctor, hospital, etc.) to make information available to patients about how they protect medical information. In order to comply with this requirement, you will be receiving a copy of our "Notice of Privacy Practices". You will find in the notice information about how WEC / NELSC uses and/or discloses medical information about you for purposes of 1) treatment, payment, and our health care operations; 2) when you have given your written permission; and, 3) complying with the law. In addition, the notice will discuss your rights as a patient in terms of your medical information maintained by WEC / NELSC.

When you receive your copy of the notice, please take the time to read and review the information. You will be asked to acknowledge (by signature) your receipt of the notice. At that time or any time in the future, should you have any questions regarding the notice, please let us know and we will answer any questions you may have.

We thank you for entrusting your care to WEC / NELSC. We will continue to work hard to honor your trust and provide the highest quality care.

Very Truly Yours,

John Wright DO,
The Wright Eye Center PC and Natural Eyes Laser and Surgery Center

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By my signature I acknowledge that I have received a copy of the Notice of Privacy Practices from The Wright Eye Center / Natural Eyes Laser and Surgery Center.

Signature

Date