SARALYN NOTARO RIETZ, M.D.
PRACTICE LIMITED TO DISEASES OF THE VITREOUS AND RETINA

MEDICAL HISTORY SHEET

NAME:________________________________ DATE____________ AGE__________ RACE________

What is the main problem that brings you here?____

In which eye?____________________________ For how long?____________________________

(check YES or NO for all questions and explain, if necessary, under EXPLANATION)

EYE HISTORY:	YES	NO	EXPLANATION
Is the vision in your RIGHT eye normal now?	_____	_____	____________________
If not, was it ever normal?	_____	_____	____________________
Is the vision in your LEFT eye normal now?	_____	_____	____________________
If not, was it ever normal?	_____	_____	____________________
Have you ever had a lazy or crossed eye?	_____	_____	____________________
Have you ever had an eye injury?	_____	_____	____________________
Do you wear glasses or contacts?	_____	_____	____________________
How old is the prescription?			____________________
Have you ever had double vision?	_____	_____	____________________
Do you have any history of glaucoma?	_____	_____	____________________
Have you ever had any eye surgery including laser? If so, please list.....	_____	_____	____________________
Do you use any eye drops, ointments, or pills for eye disease? Please list...	_____	_____	____________________

DEVELOPMENT HISTORY:			
Were you born prematurely? (if yes, birth weight and if on oxygen)	_____	_____	____________________
Did you have a normal growth rate?	_____	_____	____________________

YOUR PAST MEDICAL HISTORY:			
Are you in good general health?	_____	_____	____________________
Any allergies to drugs, dyes or foods?	_____	_____	____________________
Ever had any operations?(other than eye)	_____	_____	____________________
Ever been in the hospital for a serious problem?	_____	_____	____________________
Do you take aspirin on a regular basis?	_____	_____	____________________
Do you use tobacco products? If yes explain...	_____	_____	____________________
Do you use alcohol or drugs? If yes explain	_____	_____	____________________
Do you drink drinks with caffeine? How much?	_____	_____	____________________
Do you take any medications? Please list:	_____	_____	____________________

____

Name of all of your medical doctors: ____________________________________
____
____

REVIEW OF SYSTEMS (con't Page 2) PT NAME____________________________________

EARS, EYES, NOSE, THROAT:	YES	NO	EXPLANATION
Ever had sinus infections?	_____	_____	____________________

Ever had ringing in the ears? ______ ______ ______________________________
Ever had loss of smell? ______ ______ ______________________________

NERVOUS SYSTEM:
Ever had severe headaches? ______ ______ ______________________________
Ever had temporary blindness? ______ ______ ______________________________
Ever had any type of seizure? ______ ______ ______________________________
Ever had any numbness or unusual weakness? ______ ______ ______________________________
Ever been diagnosed with multiple sclerosis (MS) ______ ______ ______________________________

CARDIOVASCULAR:
Ever been told you have high blood pressure? ______ ______ ______________________________
Ever had high cholesterol levels? ______ ______ ______________________________
Ever had a heart attack or heart disease? ______ ______ ______________________________
Ever had fluttering or palpitations of the heart? ______ ______ ______________________________
Ever had shortness or breath with exertion? ______ ______ ______________________________
Ever had chest pain? ______ ______ ______________________________
Ever had swelling of the feet or ankles? ______ ______ ______________________________
Ever had blood clots or vein inflammation? ______ ______ ______________________________
Ever had a stroke? ______ ______ ______________________________

RESPIRATORY:
Any history of asthma? ______ ______ ______________________________
Any history of emphysema? ______ ______ ______________________________
Any problems with shortness of breath? ______ ______ ______________________________
Any other respiratory diseases? ______ ______ ______________________________

GASTROINTESTINAL:
Ever had heartburn, indigestion, or stomach
pain after eating, or ulcers? ______ ______ ______________________________
Ever been diagnosed with stomach problems
or any intestinal disease? ______ ______ ______________________________

GENITOURINARY:
Any previous diagnosis of kidney disease or
problems with urination? ______ ______ ______________________________

ENDOCRINE: (answer questions that apply)
Have you ever had thyroid problems? ______ ______ ______________________________
Ever been told you have sugar diabetes? ______ ______ ______________________________
If yes, what age diagnosed and how long ______________________________
Do you take insulin? How long? ______ ______ ______________________________
Do you take diabetic pills? How long? ______ ______ ______________________________
What is your average blood sugar? ______________________________
How often is your blood sugar checked? ______________________________

Have you ever been hospitalized for high or
low blood sugar? ______ ______ ______________________________

INFECTIOUS/INFLAMMATORY/OTHER DISEASES:	YES	NO	EXPLANATION
Any problems with arthritis?	______	______	______________________________

Any history of TB or exposure to TB? ______ ______ ______________________________
Any history of cancer? ______ ______ ______________________________
Ever been diagnosed with sickle cell anemia? ______ ______ ______________________________
Ever had syphilis or venereal disease? ______ ______ ______________________________
Ever been diagnosed with hepatitis? ______ ______ ______________________________
Ever had a blood transfusion? ______ ______ ______________________________
Ever had a positive HIV test/exposure to AIDS? ______ ______ ______________________________
When was your last tetanus shot? ______ ______ ______________________________

FAMILY HISTORY:

Has any member of your family had cataracts? ______ ______ ______________________________
Glaucoma? ______ ______ ______________________________
Detached retina? ______ ______ ______________________________
Macular degeneration? ______ ______ ______________________________
Blindness or decreased vision? ______ ______ ______________________________
Crossed or lazy eye? ______ ______ ______________________________
Diabetes? If yes, what age? ______ ______ ______________________________
Cancer? ______ ______ ______________________________
High blood pressure? ______ ______ ______________________________
Heart disease? ______ ______ ______________________________
Any other serious health problems? ______ ______ ______________________________

FEMALE:

Do you take birth control pills? ______ ______ ______________________________
Are you pregnant? Date of last period? ______ ______ ______________________________