RETINA AND UVEITIS CENTER

Ocular Inflammatory Disease Review of Systems Questionnaire

Account Number_____

This is a <u>confidential</u> survey. Please respond to all questions by circling the proper answer. Please bring with you to your appointment.

Patient information		
Last Name	First Name	Date of Birth
Reason for Visit	Date of Visit	

Family History (*These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children, or grandchildren*)

➢ Has anyone in your **<u>family</u>** had any of the following?

CONDITION	YES	NO	RELATIVE
Cancer	YES	NO	
Diabetes	YES	NO	
Allergies	YES	NO	
Arthritis or Rheumatism	YES	NO	
Syphilis	YES	NO	
Tuberculosis	YES	NO	
Sickle Cell Disease or Trait	YES	NO	
Lyme Disease	YES	NO	
Gout	YES	NO	

➢ Has anyone in your **<u>family</u>** had any of the medical problems listed below?

CONDITION	YES	NO	RELATIVE
Eyes	YES	NO	
Skin	YES	NO	
Kidneys	YES	NO	
Lungs	YES	NO	
Stomach or bowel	YES	NO	
Nervous System or brain	YES	NO	

Your Social History

QUESTION	YES	NO	FURTHER EXPLANATION
Have you ever lived outside the U.S.A.?	YES	NO	If yes, where?
Have you ever owned a dog?	YES	NO	
Have you ever owned a cat?	YES	NO	
Have you ever eaten raw meat or uncooked sausage?	YES	NO	
Have you ever had unpasteurized milk or cheese?	YES	NO	
Have you ever been exposed to sick animals?	YES	NO	
Do you ever drink untreated stream, well or lake water?	YES	NO	
Do you currently use tobacco products?	YES	NO	
Have you ever used recreational drugs injected into the vein?	YES	NO	
Have you ever had bisexual or same-sex relationships?	YES	NO	
Do you currently take, or have you taken birth control pills in the last 5 years?	YES	NO	

➢ Have you ever been told that you have the following conditions?			
CONDITION	**YES**	**NO**	**DIAGNOSED YEAR OR DATE**
Anemia (Low blood counts)	YES	NO	
Cancer	YES	NO	
Diabetes	YES	NO	
Hepatitis	YES	NO	
High Blood Pressure	YES	NO	
Pleurisy	YES	NO	
Pneumonia	YES	NO	
Ulcers	YES	NO	
Herpes (cold sores)	YES	NO	
Chicken Pox	YES	NO	
Shingles (Zoster)	YES	NO	
German Measles (Rubella)	YES	NO	
Measles (Rubeola)	YES	NO	
Mumps	YES	NO	
Chlamydia or Trachoma	YES	NO	
Syphilis	YES	NO	
Gonorrhea	YES	NO	
Any other sexually transmitted disease	YES	NO	
Tuberculosis (TB)	YES	NO	
Leprosy	YES	NO	
Leptospirosis	YES	NO	
Lyme Disease	YES	NO	
Histoplasmosis	YES	NO	
Candida or Moniliasis	YES	NO	
Coccidiomycosis	YES	NO	
Sporotrichosis	YES	NO	
Toxoplasmosis	YES	NO	
Toxocariasis	YES	NO	
Cysticercosis	YES	NO	
Trichinosis	YES	NO	
Whipple's Disease	YES	NO	
AIDS	YES	NO	

➢ Have you ever been told that you have the following conditions?			
CONDITION	**YES**	**NO**	**FURTHER EXPLANATION/DIAGNOSED YEAR OR DATE**
Hay Fever	YES	NO	
Allergies	YES	NO	
Vasculitis	YES	NO	
Arthritis	YES	NO	
Rheumatoid Arthritis	YES	NO	
Lupus (Systemic Lupus Erythematosus)	YES	NO	
Scleroderma	YES	NO	

➢ Have you ever had any of the following illnesses?			
ILLNESS	**YES**	**NO**	**DIAGNOSED YEAR OR DATE**
Reiter's Syndrome	YES	NO	
Colitis	YES	NO	

Crohn's Disease	YES	NO	
Ulcerative Colitis	YES	NO	
Behcet's Disease	YES	NO	
Sarcoidosis	YES	NO	
Ankylosing Spondylitis	YES	NO	
Erythema Nodosa	YES	NO	
➢ Have you ever had any of the following illnesses?			
ILLNESS	**YES**	**NO**	**DIAGNOSED YEAR OR DATE**
Temporal Arteritis	YES	NO	
Multiple Sclerosis	YES	NO	
Serpiginous Choroidopathy	YES	NO	
Fuchs' Heterochromic Iridocyclitis	YES	NO	
Vogt-Koyanagi-Harada Syndrome	YES	NO	
➢ Have you had any of the following symptoms in the past year?			
SYMPTOM	**YES**	**NO**	**FURTHER EXPLANATION**
GENERAL HEALTH			
Chills	YES	NO	
Fevers (persistent or recurrent)	YES	NO	
Night Sweats	YES	NO	
Fatigue (tire easily)	YES	NO	
Poor Appetite	YES	NO	
Unexplained Weight Loss	YES	NO	
Do you feel sick?	YES	NO	
HEAD			
Frequent or Severe Headaches	YES	NO	
Fainting	YES	NO	
Numbness or tingling in your body	YES	NO	
Paralysis in parts of your body	YES	NO	
Seizures or convulsions	YES	NO	
EARS			
Hard of hearing or deafness	YES	NO	
Ringing or noises in your ears	YES	NO	
Frequent or severe ear infections	YES	NO	
Painful or swollen ear lobes	YES	NO	
NOSE AND THROAT			
Sores in your nose or mouth	YES	NO	
Severe or recurrent nosebleeds	YES	NO	
Frequent sneezing	YES	NO	
Sinus trouble	YES	NO	
Persistent hoarseness	YES	NO	
Tooth or gum infections	YES	NO	
SKIN			
Rashes	YES	NO	
Skin sores	YES	NO	
Sunburn easily (photosensitivity)	YES	NO	
White patches of skin or hair	YES	NO	
Loss of hair	YES	NO	

Tick or insect bite	YES	NO	
Painfully cold fingers	YES	NO	
Severe itching	YES	NO	
RESPIRATORY			
Severe or frequent colds	YES	NO	
Constant coughing	YES	NO	
Coughing up blood	YES	NO	
Recent flu or viral infection	YES	NO	
Wheezing or asthma attacks	YES	NO	
Difficulty breathing	YES	NO	
CARDIOVASCULAR			
Chest pain	YES	NO	
Shortness of breath	YES	NO	
Swelling of your legs	YES	NO	
BLOOD			
Frequent or easy bruising	YES	NO	
Frequent or easy bleeding	YES	NO	
Have you received blood transfusions	YES	NO	
GASTROINTESTINAL			
Trouble swallowing	YES	NO	
Diarrhea	YES	NO	
Bloody stools	YES	NO	
Stomach ulcers	YES	NO	
Jaundice or yellow skin	YES	NO	
BONES AND JOINTS			
Stiff joints	YES	NO	
Painful or swollen joints	YES	NO	
Stiff lower back	YES	NO	
Back pain while sleeping or awakening	YES	NO	
Muscle aches	YES	NO	
GENITOURINARYN			
Kidney problems	YES	NO	
Bladder trouble	YES	NO	
Blood in urine	YES	NO	
Urinary discharge	YES	NO	
Genital sores or ulcers	YES	NO	
Prostatitis	YES	NO	
Testicular pain	YES	NO	
OTHER			
Are you pregnant?	YES	NO	
Do you plan to be pregnant in the future?	YES	NO	