CHARLOTTE EYE
EAR NOSE & THROAT
ASSOCIATES, P.A.

Ocular Inflammatory Disease Questionnaire

Please respond to all questions

Patient Name**:** _____
Date of birth: _____
Primary Care Doctor: _____
Referring Provider: _____

YOUR Past Medical History

List any medical conditions for which YOU receive treatment or see a physician.

_____

_____

_____

_____

_____

_____

_____

List any surgeries (except for eye) YOU have had on any part of your body.

_____

_____

_____

_____

_____

_____

List any serious injuries or hospitalizations <u>YOU</u> have had.

_____

_____

_____

_____

List any eye problems (including surgeries, injuries, or diseases) <u>YOU</u> have been treated for.

_____

_____

_____

_____

Have <u>YOU</u> ever been diagnosed with uveitis, iritis, or scleritis?

YES

NO

If YES, list:

Date of first flare: _____

Number of flares: _____

How many weeks/months between flares: _____

Any bloodwork/Xrays for work-up: _____

Medications used for treatment: _____

_____

Have <u>YOU</u> been diagnosed with any of the following conditions?

□ Crohn's disease/ulcerative colitis
□ Ankylosing spondylitis
□ Arthritis with warm, red, swollen joints (rheumatoid arthritis, juvenile idiopathic arthritis or JIA, psoriatic arthritis, or reactive arthritis)
□ Psoriasis
□ Sarcoidosis
□ Vasculitis
□ Lupus
□ Behcet's disease
□ Multiple sclerosis

□ Syphilis
□ Tuberculosis
□ Shingles
□ Herpes cold sores
□ HIV/AIDS
□ Hepatitis
□ Whipple disease

□ Cancer

□ **None of these**

<u>Medication History</u>

List your current medications, with doses if possible (including supplements).

_____

_____

_____

_____

_____

Have you taken or are you taking Fosamax (alendronate), Actonel (risedronate), or Boniva (ibandronate)?

□ Yes □ No

List any allergies to medications.

_____

_____

List your:

Usual weight: _____ lbs Current weight: _____ lbs Height: _____

Review of systems

Have **YOU** recently (6-12 months) experienced any of the following **symptoms**?

□ Fevers
□ Chills
□ Unintentional weight loss
□ Night sweats
□ Fatigue/poor appetite
□ Lip cold sores/fever blisters
□ Painful sores inside the mouth
□ Upper respiratory infection (cold, cough, sinus infections requiring antibiotics)
□ Sinus problems – seasonal or chronic
□ Ear problems (hearing, ringing, painful earlobes)
□ Chest pain
□ Shortness of breath
□ Chronic cough
□ Stomach pain
□ Diarrhea
□ Blood in the stool
□ Painful urination
□ Blood in the urine
□ Genital sores
□ Testicular pain
□ Skin rashes/problems
□ White patches on skin or premature loss or whitening of hair
□ Tick bites with rash at site of bite
□ Fingers/toes that are painful when exposed to cold or Raynaud's phenomenon
□ Warm, red, swollen joints
□ Low back pain worse after inactivity
□ Numbness or tingling
□ Headache

□ **None of the above**

Family History

Do any of the following members of your family have medical problems? Please list below.

Father: _____

Mother: _____

Brother(s):_____

Sister(s):_____

Maternal grandfather: _____

Maternal grandmother: _____

Paternal grandfather: _____

Paternal grandmother: _____

In addition, has anyone in your family had any of the following:

Relative??

□ Iritis, uveitis, scleritis, eye inflammation _____

□ Arthritis with warm, red, swollen joints _____

□ Crohn's disease/ulcerative colitis (inflammatory bowel disease) _____

□ Back problems, especially low back pain or stiffness _____

□ **None of these**

Social History

In what country were you born? _____

Have you lived outside the US?

□ Yes **Where?** _____

□ No

List all states you have lived in?

_____

_____

_____

List any travels outside the US.

_____

_____

Racial/Ethnic Group Identification (check all that apply):

□ Native American
□ African American, not of Hispanic origin
□ Mexican American
□ Cuban
□ Asian or Pacific Islander
□ Caucasian, not of Hispanic origin
□ Puerto Rican
□ Other Hispanic (specify): _____
□ Other (specify): _____

Do you or have you smoked?

□ Yes **How much?** _____
□ No

Do you or have you consumed alcohol?

□ Yes **How much?** _____
□ No

Do you or have you used recreational drugs?

□ Yes **If yes, what form (IV, inhaled)?** _____

□ No

Do you eat raw meats or hamburgers?
□ Yes □ No

Do you have any pets?
□ Yes **List:** _____
□ No

Have you ever been diagnosed with any of the following sexually transmitted diseases?
□ Gonorrhea □ Chlamydia □ Syphilis □ HIV □ **None**

Have you ever had a bisexual or homosexual relationship?
□ Yes □ No

Do you have any risk factors for HIV infection (e.g. intravenous drug use, unprotected sex, blood transfusion prior to 1985 or in a developing country)?
□ Yes □ No

Have you ever been exposed to or treated for tuberculosis?
□ Yes □ No

Have you ever had a tick bite?
□ Yes □ No

_____ _____
Patient signature **Date**