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 **YOU** have had.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

List any eye problems (including surgeries, injuries, or diseases) **YOU** have been treated for.

___________________________________________________________________
___________________________________________________________________
___________________________________________________________________
___________________________________________________________________

Have **YOU** 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 **YOU** 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

**Medication History**
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:

☑ 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? _______________________________________________________
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)? _________________________________
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