Patient Name: _____

Uveitis and Ocular Immunologic Disease New Patient Questionnaire

This is a **confidential** questionnaire intended to assist in the treatment of your eye condition. Please respond to all questions to the best of your ability and bring this completed survey with you to your appointment.

Date of Birth: _____
Reason for Visit: _____

Family History: These questions refer to your grandparents, parents, aunts, uncles, brothers and sisters, children, or grandchildren.

Has anyone in your **family** had any of the following eye conditions?

		Details
Uveitis	NO	YES:
Scleritis	NO	YES:
Other eye inflammation	NO	YES:
Cataract	NO	YES:
Glaucoma	NO	YES:
Macular Degeneration	NO	YES:
Other	NO	YES:

Has anyone in your **family** had any of the following?

		Details
Arthritis or Rheumatism	NO	YES:
Sarcoidosis	NO	YES:
Lupus	NO	YES:
Scleroderma	NO	YES:
Other Autoimmune disease	NO	YES:
Tuberculosis (TB)	NO	YES:
Cancer	NO	YES:
Diabetes	NO	YES:
Multiple Sclerosis	NO	YES:
Sickle cell disease or trait	NO	YES:
Skin problems	NO	YES:
Heart or lung problems	NO	YES:
Kidney problems	NO	YES:
Stomach or bowel problems	NO	YES:
Nervous system or brain problems	NO	YES:

Patient Name: _____

The remainder of this survey contains questions regarding yourself.

Physicians involved in your current care:

Name:	Specialty:

Past Medical/Surgical History:

Eye Conditions and Eye Surgeries	Date

All Other Medical Problems	Date

Non-Eye Surgeries	Date

Patient Name: _____

Other:

Are you pregnant?	NO	YES
Do you plan to become pregnant in the future?	NO	YES
Do you currently take, or have you taken birth control pills in the last 5 years?	NO	YES

Social History:

Current Job (If unemployed or retired, former occupation): _____

Have you lived/traveled outside the US?	NO	YES
If yes to question above, where?		
Have you ever owned a dog?	NO	YES
Have you ever owned a cat?	NO	YES
Have you ever owned any other pets?	NO	YES
Have you eaten raw meat or uncooked sausage?	NO	YES
Have you ever been exposed to sick animals?	NO	YES
Do you ever drink untreated stream, well, or lake water?	NO	YES
Have you ever injected recreational drugs into a vein?	NO	YES
Have you ever had bisexual or homosexual relationships?	NO	YES

Tobacco/Alcohol Use:

Do you currently use tobacco products?	NO	YES
Do you consume alcohol?	NO	YES

Patient Name: _____

Allergies:

Are you allergic to any medications?	NO	YES
Please list all allergies, including medications and reactions to them:		

Eye Medications: Please list all EYE drops and EYE medications that you are taking (or have recently taken). If relevant, please include medications discontinued for either lack of benefit or side effects.

Drug Name	Dosage	How Often/Which eye
Current Eye Medications:		
Previous Eye Medications:		

Other Medications: List all other medications.

Drug Name	Dosage	How Often

Patient Name: _____

Have you ever had (or been told that you have) the following conditions?

		Details
Anemia (low blood counts)	NO	YES:
Cancer	NO	YES:
Diabetes	NO	YES:
Hepatitis	NO	YES:
High Blood Pressure	NO	YES:
Pneumonia	NO	YES:
Ulcers	NO	YES:
Herpes (cold sores)	NO	YES:
Chicken Pox	NO	YES:
Shingles (Zoster)	NO	YES:
Chlamydia or Trachoma	NO	YES:
Syphilis	NO	YES:
Gonorrhea	NO	YES:
Other sexually transmitted disease	NO	YES:
Tuberculosis TB	NO	YES:
Leprosy	NO	YES:
Leptospirosis	NO	YES:
Lyme Disease	NO	YES:
Histoplasmosis	NO	YES:
Candida	NO	YES:
Coccidiomycosis	NO	YES:
Sporotrichosis	NO	YES:
Toxoplasmosis	NO	YES:
Toxocariasis	NO	YES:
Cysticercosis	NO	YES:
Trichinosis	NO	YES:
Whipple's Disease	NO	YES:
HIV or AIDS	NO	YES:

Patient Name: _____

Have you ever had (or been told that you have) the following conditions?

		Details
Allergies or Hay Fever	NO	YES:
Vasculitis	NO	YES:
Arthritis	NO	YES:
Rheumatoid Arthritis	NO	YES:
Lupus (Systemic Lupus Erythematosus)	NO	YES:
Scleroderma	NO	YES:
Reactive arthritis	NO	YES:
Colitis	NO	YES:
Crohn's Disease	NO	YES:
Ulcerative Colitis	NO	YES:
Behcet's Disease	NO	YES:
Sarcoidosis	NO	YES:
Ankylosing Spondylitis	NO	YES:
Erythema Nodosa	NO	YES:
Temporal Arteritis (Giant cell arteritis)	NO	YES:
Multiple Sclerosis	NO	YES:
Serpiginous Choroidopathy	NO	YES:
Fuchs' Heterochromic Iridocyclitis	NO	YES:
Vogt-Koyanagi-Harada Syndrome	NO	YES:

General Health: Have you had any of the following symptoms in the past year?

		Details
Fevers (persistent or recurrent)	NO	YES:
Chills	NO	YES:
Night Sweats	NO	YES:
Fatigue (tire easily)	NO	YES:
Poor Appetite	NO	YES:
Unexplained weight loss	NO	YES:

Patient Name: _____

Have you had any of the following symptoms in the past year?

Head:

		Details
Headaches	NO	YES:
Numbness or tingling in your body	NO	YES:
Paralysis in parts of your body	NO	YES:
Seizures or convulsions	NO	YES:

Ears:

		Details
Hard of hearing or deafness	NO	YES:
Ringing or noises in your ears	NO	YES:
Frequent or severe ear infections	NO	YES:
Painful or swollen ear lobes	NO	YES:

Nose, Mouth, and Throat:

		Details
Severe or recurrent nosebleeds	NO	YES:
Sinus trouble	NO	YES:
Sores in your nose or mouth	NO	YES:
Tooth or gum infections	NO	YES:
Recent dental work	NO	YES:
Persistent hoarseness	NO	YES:

Skin:

		Details
Skin sores	NO	YES:
Sunburn easily (Photosensitivity)	NO	YES:
White patches of skin or hair	NO	YES:
Loss of hair	NO	YES:
Tick or insect bites	NO	YES:
Painfully cold fingers	NO	YES:
Severe itching	NO	YES:
Rashes	NO	YES:

Patient Name: _____

Have you had any of the following symptoms in the past year?

Respiratory:

		Details
Constant coughing	NO	YES:
Coughing up blood	NO	YES:
Recent flu or viral infection	NO	YES:
Wheezing or asthma attacks	NO	YES:
Difficulty breathing	NO	YES:

Cardiovascular:

		Details
Shortness of breath	NO	YES:
Swelling of your legs	NO	YES:
Chest pain	NO	YES:

Blood:

		Details
Frequent or easy bleeding	NO	YES:
Have you received blood transfusions?	NO	YES:

Gastrointestinal:

		Details
Diarrhea	NO	YES:
Bloody stools	NO	YES:
Stomach ulcers	NO	YES:
Jaundice or yellow skin	NO	YES:
Trouble swallowing	NO	YES:

Bones and Joints:

		Details
Painful or swollen joints	NO	YES:
Stiff lower back	NO	YES:
Stiff joints	NO	YES:
Muscle aches	NO	YES:

Patient Name: _____

Have you had any of the following symptoms in the past year?

Genitourinary:

		Details
Bladder trouble	NO	YES:
Blood in your urine	NO	YES:
Urinary discharge	NO	YES:
Genital sores or ulcers	NO	YES:
Prostatitis	NO	YES:
Testicular pain	NO	YES:
Kidney problems	NO	YES: