

UVEITIS QUESTIONS

FAMILY HISTORY

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

Has anyone in family had:

- 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

Has anyone in your family had medical problems of the:

- EyesYes No
- SkinYes No
- KidneysYes No
- LungsYes No
- Stomach or bowelYes No
- Nervous system or brainYes No

SOCIAL HISTORY

Age (years) _____

Current job _____

Have you lived outside of the U.S.?.....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 been exposed to sick animals?Yes No
- Do you drink untreated stream, well, or lake water?Yes No
- Do you smoke cigarettes?Yes No
If yes, how many? _____
- Have you ever used intravenous drugs?Yes No

Have you ever taken birth control pills?Yes No
Have you ever had a bisexual or homosexual relationship?Yes No

PERSONAL MEDICAL HISTORY

Are you allergic to any medications?Yes No
If yes, which medication? _____

Please list the *medicines* you are currently taking including nonprescription drugs such as aspirin, ibuprofen, antihistamines, etc...

MEDICAL HISTORY

Please list all eye operations you have had (including laser surgery) and the dates of the surgeries.

Have you ever had any of the following illnesses?

- CancerYes No
- Diabetes.....Yes No
- Hepatitis.....Yes No
- High blood PressureYes No
- Anemia (low blood cell counts)Yes No
- Pneumonia or pleurisy.....Yes No
- TuberculosisYes No
- Herpes (cold sores)Yes No
- Chicken poxYes No
- Shingles (zoster)Yes No
- German measles (rubella)Yes No
- Measles (rubeola)Yes No

UVEITIS QUESTIONS

MumpsYes No
Chlamydia or trachomaYes No
SyphilisYes No
Any other sexually transmitted disease...Yes No
LeprosyYes No
LeptospirosisYes No
Lyme diseaseYes No
HistoplasmosisYes No
Candidiasis or moniliasisYes No
CoccidioidomycosisYes No
SporotrichosisYes No
Cryptococcal infectionYes No
ToxoplasmosisYes No
Amoeba infectionYes No
GiardiasisYes No
ToxocariasisYes No
CysticercosisYes No
TrichinosisYes No
Whipple's diseaseYes No
AIDSYes No
Hay feverYes No
VasculitisYes No
ArthritisYes No
Rheumatoid arthritisyes No
Lupus (systemic lupus erythematosus)Yes No
SclerodermaYes No
Reiter's syndromeYes No
ColitisYes No
Crohn's diseaseYes No
Ulcerative colitisYes No
Behcet's diseaseYes No
SarcoidosisYes No
Ankylosing spondylitisYes No
Erythema nodosumYes No
Temporal arteritisYes No
Multiple sclerosisYes No
Serpiginous choroidopathyyes No
Fuchs' heterochromic iridocyclitisYes No
Vogt-Koyanagi-Harada syndromeYes No

GENERAL HEALTH

ChillsYes No
Fever (persistent or recurrent)Yes No
Night sweatsYes No
Fatigue (tire easily)Yes No
Poor appetiteYes No
Unexplained weight lossYes No

Do you feel sick?Yes No

NEUROLOGIC

Frequent or severe headachesYes No
FaintingYes No
Numbness or tingling in your bodyYes No
Paralysis or weakness in parts of
your bodyYes No
Seizures or convulsionsYes No
Psychiatric conditionsYes No

EARS

Hard of hearing or deafnessYes No
Ringing or noises in your earsYes No
Frequent or severe ear infectionsYes No
Painful or swollen ear lobesYes No

NOSE AND THROAT

Sores in your nose or mouthYes No
Severe or recurrent nosebleedsYes No
Frequent sneezingYes No
Sinus troubleYes No
Persistent hoarsenessYes No
Tooth or gum infectionsYes No

SKIN

Rashes
Skin sores
Sunburn easily (photosensitivity)
White patches of skin or hair
(vitiligo or poliosis)
Loss of hair
Tick or severe insect bites
Painfully cold fingers
Severe itching

RESPIRATORY

Severe or frequent coldsYes No
Constant coughingYes No
Coughing up bloodYes No
Recent flu or viral infectionYes No
Wheezing or asthma attacksYes No
Difficulty in breathingYes No

UVEITIS QUESTIONS

CARDIOVASCULAR

Chest painYes No
Shortness of breathYes No
Swelling of your legsYes No

BLOOD

Frequent or easy bruisingYes No
Frequent or easy bleedingYes No
Have you received blood transfusion?Yes No

BONES AND JOINTS

Stiff jointsYes No
Painful or swollen jointsYes No
Stiff lower backYes No
Back pain while sleeping or
on awakeningYes No
Muscle achesYes No

GENITOURINARY

Kidney problemsYes No
Bladder troubleYes No
Blood in your urineYes No
Urinary dischargeYes No
Genital sores or ulcersYes No
ProstatitisYes No
Testicular painYes No
Are you pregnant?Yes No
Do you plan to become pregnant in the near
future?Yes No