Uveitis Questionnaire

NAME:

DATE:

Please take your time in answering this long questionnaire. The answers are critical in determining the cause of your eye problem and finding the best treatment.

Symptoms: (circle options separated by slash marks)

Symptoms have been present for days/weeks/months/years

The problem came on suddenly/gradually

Does anything bring it on, make it worse, or make it better? _____

How many total episodes? _____

When was the first episode? _____

How frequently do the episodes occur? Weekly/monthly/yearly _____

The symptoms include: pain/redness/tearing/light sensitivity/floating dots in my vision/loss of vision/blind spots in the vision/straight lines look wavy/other _____

Past treatments included: eye drops/medicine injection/pills. Explain _____

Past medical History:

Did the eye symptoms come on after any trigger or infection apart from the eye?

Have you had any serious past infection?

Have you had past eye inflammations?

Have you ever had an autoimmune disorders (for example: lupus, rheumatoid arthritis, inflammatory bowel disease)?

Have you been exposed to tuberculosis or sexually transmitted disease in the past?

Have you had any recent vaccinations?

Social History:

Have you had exposure to any type of animals/animal products (pets, farm, travel, occupation, hobby; exposure to raw meat, urine, feces water/earth contamination)?

Have you lived in or traveled to Southwest US or Mississippi/Ohio/Missouri River Valley areas?

Have you any international or exotic travel history?

Please list past and present occupations:

Please list past and present hobbies/activities/recreational activities:

Have you had swelling or irritation of any tatoos?

Family History:

Any family member with autoimmune disorders (for example: lupus, rheumatoid arthritis, inflammatory bowel disease)?

Any family member with an inherited condition?

Review of Medical Systems:

PLEASE CIRCLE YES or NO if you have/had problems in a part of the body – If Yes: √
Check any specific symptoms

Nose: Yes / No
____ Loss of Smell
____ Itching / allergies
____ Sinus pain
____ Nose bleeds
____ Chronic sinusitis

Ears: Yes / No
____ Ringing
____ Hearing loss
____ Infection
____ Dizziness/Vertigo

Genito-Urinary: Yes / No
____ Ulcers or sores on genitals
____ Pain on urination
____ Blood in urine
____ Kidney disease
____ Pregnant
____ Past sexually transmitted disease: _____

Musculoskeletal: Yes / No
____ Neck stiffness / pain
____ Lower back stiffness / pain
____ Joint pain
____ Join swelling
____ Osteoporosis
____ Shoulder ache
____ Hip ache
____ Arthritis (specify): _____
____ Hand increase in size
____ Head / hat size increase

Mouth: Yes / No
_____ Ulcers or sores in mouth
_____ Jaw cramping
_____ Chewing pain
_____ Painful to talk
_____ Tooth infection
_____ Hard to swallow

Skin / Hair / Nails: Yes / No
_____ Skin rash
_____ Skin color change
_____ Hair increase
_____ Nail changes
_____ Skin ulcers
_____ Tender nodes

Psychiatric: Yes / No
_____ Difficult sleep
_____ Hallucinations
_____ Claustrophobia
_____ Loss of ability to think clearly
_____ Alzheimer's

Cardio-vascular: Yes / No
_____ Chest pain at rest
_____ Chest pain on exertion
_____ Faintness
_____ Poor circulation
_____ Heartbeat skips
_____ Murmur
_____ High cholesterol
_____ Blood disorder
_____ Bleeding disorder
_____ Clotting problem

Neurological: Yes / No
_____ Numbness
_____ Weakness
_____ Seizures
_____ Memory loss
_____ Unconsciousness
_____ Headaches
_____ Head Trauma
_____ Tender Scalp

Allergic: Yes / No
_____ Itching
_____ Sneezing
_____ Watering eyes
_____Asthma

Respiratory: Yes / No
_____ Breath shortness
_____ Unable to breathe lying down
_____ Chest pressure
_____ Productive cough
_____ Bloody spit
_____ TB Exposure

Endocrine: Yes / No
_____ Palpitations
_____ Increased thirst
_____ Weight loss
_____ Loss of appetite
_____ Night sweats
_____ Chills
_____ Fatigue
_____ Fever

Known allergies: Yes / No
_____ Penicillin
_____ Codeine
_____ Sulfa drugs
_____ Iodine
_____ Shell Fish
_____ Other allergies:

Gastro-intestinal: Yes / No
_____ Diarrhea
_____ Abdominal pain
_____ Nausea / vomiting
_____ Fullness
_____ Mass
_____ Blood in stool
_____ Jaundice
_____ Liver problems
_____ Hepatitis

Lymphatic: Yes / No
_____ Tender nodes
_____ Swollen nodes

_____ Travel outside U.S.
_____ Unusual sports/hobbies
_____ Unusual jobs/activities
_____ Exposure to infections
_____
_____
_____
_____