UVEITIS New patient questionnaire

Name : _____
DOB: _____
MRN: _____

Referring physician:_____

What are you being referred for/what eye problem are you having?

_____

What are your medical problems:

_____
_____
_____

What eye problems have you had in the past:

_____
_____
_____

Current medications by mouth: Eye drops:

_____
_____
_____
_____

Please check the following:

	Yes	**No**
Recent cold or illness		
Recent vaccines		
Recent changes to weight		
Night sweats		

Name: _____ DOB:_____

Headaches		
Hearing problems		
Sores or ulcers in your nose		
Frequent nose bleeds		
Trouble swallowing		
Trouble breathing		
Heart problems		
Joint or low back pain		
Diarrhea		
Numbness or tingling in hands or feet		
Rashes on your skin		
Cold sores		
Genital ulcers		
Miscarriages (if applicable)		
Tattoos		

Were you born outside of the United States? **Yes/No**
Have you lived internationally? **Yes/No**
Do you frequently travel internationally? **Yes/No**
Do you have any new or unusual pets? **Yes/No**
Do you consume raw or undercooked meat? **Yes/No**
What do you do for work (current or previous)?_____
Do you smoke? **Yes/Never/Quit**
Do you drink? **Yes/No/Socially**
Any history of/current intravenous drug use? **Yes/No**
Have you ever had any sexually transmitted diseases? **Yes/No**
Have you ever been incarcerated? **Yes/No**

Name: _____ DOB:_____

Family members

Does anyone in your family have a history of eye inflammation? _____
Does anyone in your family have any autoimmune (inflammation) problems or see a rheumatologist? _____

If yes, please check what problems they have:

- ❑ rheumatoid arthritis
- ❑ Multiple sclerosis
- ❑ Inflammatory bowel disease (Crohn's or ulcerative colitis)

Does anyone in your family have cancer? _____

If yes, who and what kind of cancer?_____

Is anyone in your family blind?_____

If yes, from what cause?_____

Does anyone in your family have high eye pressures or glaucoma? _____