WHEATON
EYE CLINIC

Ocular Inflammatory Disease Review of Systems Questionnaire

This is a **confidential** survey. Please respond to all questions. Please bring with you to your appointment.

Name:_____

Date of Birth:_____ **Reason for visit**:_____

Referring Doctor:_____
Address/phone #:_____

Primary Care Doctor:_____
Address/phone #:_____

Rheumatologist:_____
Address/phone #:_____

Pulmonologist:_____
Address/phone #:_____

Ophthalmologist:_____
Address/phone #:_____

Endocrinologist:_____
Address/phone #:_____

Gastroenterologist:_____
Address/phone #:_____

Dermatologist:_____
Address/phone #:_____

Psychologist:_____
Address/phone #:_____

Other Doctors:_____
Address/phone #:_____

What hospital did you go to?_____

Which Lab do you go to for blood tests?_____
Your SOCIAL HISTORY:
Current job: Employer:

Have you lived outside the U.S.A.?	**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 eaten unpasteurized milk or cheese?	**YES**	**NO**
Have you ever been exposed to sick animals?	**YES**	**NO**
Do you ever drink untreated stream, well, or lake water?	**YES**	**NO**
Do you currently use tobacco products?	**YES**	**NO**
Have you ever used recreational drugs injected in the vein?	**YES**	**NO**
Have you ever had bisexual or homosexual relationships?	**YES**	**NO**

PAST Medical/Surgical HISTORY:
Please list all **Eye Conditions and Surgeries** with dates:

Eye Medical Condition and Eye Surgeries	Date

Please list all other **Medical History**:

Medical Health Problems	Date

Have you ever been told that you have the following conditions?

Anemia (Low Blood Counts)	**YES**	**NO**
Cancer	**YES**	**NO**
Diabetes	**YES**	**NO**
Hepatitis	**YES**	**NO**
High Blood Pressure	**YES**	**NO**
Pleurisy	**YES**	**NO**
Pneumonia	**YES**	**NO**
Ulcers	**YES**	**NO**
Herpes (cold sores)	**YES**	**NO**
Chicken Pox	**YES**	**NO**
Shingles (Zoster)	**YES**	**NO**
German Measles (Rubella)	**YES**	**NO**
Measles (Rubeola)	**YES**	**NO**
Mumps	**YES**	**NO**
Chlamydia or Trachoma	**YES**	**NO**
Syphilis	**YES**	**NO**
Gonorrhea	**YES**	**NO**
Any other sexually transmitted disease	**YES**	**NO**
Tuberculosis (TB)	**YES**	**NO**
Leprosy	**YES**	**NO**
Leptospirosis	**YES**	**NO**
Lyme Disease	**YES**	**NO**
Histoplasmosis	**YES**	**NO**
Candida or Moniliasis	**YES**	**NO**
Coccidiomycosis	**YES**	**NO**
Sporotrichosis	**YES**	**NO**
Toxoplasmosis	**YES**	**NO**
Toxocariasis	**YES**	**NO**

Cysticercosis	**YES**	**NO**
Trichinosis	**YES**	**NO**
Whipple's Disease	**YES**	**NO**
AIDS	**YES**	**NO**
Hay Fever	**YES**	**NO**
Allergies	**YES**	**NO**
Vasculitis	**YES**	**NO**
Arthritis	**YES**	**NO**
Rheumatoid Arthritis	**YES**	**NO**
Lupus (Systemic Lupus Erythematosus)	**YES**	**NO**
Scleroderma	**YES**	**NO**

Have you ever had any of the following illnesses?

Reiter's Syndrome	**YES**	**NO**
Colitis	**YES**	**NO**
Crohn's Disease	**YES**	**NO**
Ulcerative Colitis	**YES**	**NO**
Behcet's Disease	**YES**	**NO**
Sarcoidosis	**YES**	**NO**
Ankylosing Spondylitis	**YES**	**NO**
Erythema Nodosum	**YES**	**NO**
Temporal Arteritis	**YES**	**NO**
Multiple Sclerosis	**YES**	**NO**
Serpiginous Choroidopathy	**YES**	**NO**
Fuchs' Heterochoromic Ididocyclitis	**YES**	**NO**
Vogt-Koyanagi-Harada Syndrome	**YES**	**NO**

Have you ever had any of the following symptoms in the <u>past year</u>?
GENERAL HEALTH:

Chills	**YES**	**NO**
Fevers (persistent or recurrent)	**YES**	**NO**
Night Sweats	**YES**	**NO**
Fatigue (tire easily)	**YES**	**NO**

Poor Appetite	YES	NO
Unexplained Weight Loss	YES	NO
Do you feel sick?	YES	NO

Have you had any of the following in the <u>past year</u>?

HEAD:

Frequent or Severe Headaches	YES	NO
Fainting	YES	NO
Numbness or Tingling in your body	YES	NO
Paralysis in parts of your body	YES	NO
Seizures or Convulsions	YES	NO

EARS:

Hard of Hearing or Deafness	YES	NO
Ringing or Noises in Your Ears	YES	NO
Frequent or Severe Ear Infections	YES	NO
Painful or swollen Ear Lobes	YES	NO

NOSE AND THROAT:

Sores in Your Nose or Mouth	YES	NO
Severe or Recurrent Nosebleeds	YES	NO
Frequent Sneezing	YES	NO
Sinus Trouble	YES	NO
Persistent Hoarseness	YES	NO
Tooth or Gum Infections	YES	NO

SKIN:

Rashes	YES	NO
Skin Sores	YES	NO
Sunburn Easily (Photosensitivity)	YES	NO
White Patches of Skin or Hair	YES	NO
Loss of Hair	YES	NO
Tick or Insect Bites	YES	NO
Painfully Cold Fingers	YES	NO
Severe Itching	YES	NO

Have you ever had any of the following symptoms in the <u>past year</u>?

RESPIRATORY:

Severe or Frequent Colds	**YES**	**NO**
Constant Coughing	**YES**	**NO**
Coughing Up Blood	**YES**	**NO**
Recent Flu or Virus Infection	**YES**	**NO**
Wheezing or Asthma Attacks	**YES**	**NO**
Difficulty Breathing	**YES**	**NO**

CARDIOVASCULAR:

Chest Pain	**YES**	**NO**
Shortness of Breath	**YES**	**NO**
Swelling of your legs	**YES**	**NO**

BLOOD:

Frequent or Easily Bruising	**YES**	**NO**
Frequent or Easily Bleeding	**YES**	**NO**
Have you Received Blood Transfusions	**YES**	**NO**

GASTROINTESTINAL:

Trouble Swallowing	**YES**	**NO**
Diarrhea	**YES**	**NO**
Bloody Stools	**YES**	**NO**
Stomach Ulcers	**YES**	**NO**
Jaundice or Yellow Skin	**YES**	**NO**

BONES AND JOINTS:

Stiff Joints	**YES**	**NO**
Painful or Swollen joints	**YES**	**NO**
Stiff Lower Back	**YES**	**NO**
Back Pain while Sleeping or Awakening	**YES**	**NO**
Muscle Aches	**YES**	**NO**

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

Kidney Problems	**YES**	**NO**
Bladder Trouble	**YES**	**NO**
Urinary Discharge	**YES**	**NO**
Blood in your Urine	**YES**	**NO**
Genital Sores or Ulcers	**YES**	**NO**
Prostatitis	**YES**	**NO**
Testicular Pain	**YES**	**NO**

OTHER:

Are you Pregnant?	**YES**	**NO**
Do you Plan to be Pregnant in the Future?	**YES**	**NO**

FAMILY HISTORY: These questions refer to your grandparents, parents, aunts, uncles, brothers, sisters, children, or grandchildren.
Has anyone in your family had medical problems listed above?

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**	
Gout	**YES**	**NO**	

Has anyone in your family had medical problems listed above?

Eyes	**YES**	**NO**	
Skin	**YES**	**NO**	
Kidneys	**YES**	**NO**	
Lungs	**YES**	**NO**	
Stomach or bowel	**YES**	**NO**	
Nervous System or Brain	**YES**	**NO**	