Massachusetts Eye Research and Surgery Institution

Ocular Inflammatory Disease Review of Systems Questionnaire

This is a **confidential** survey. Please respond to all questions by circling the proper answer. Please bring with you to your appointment.

Name: ____

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?

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**	

Patient Name: ____

Has anyone in your **family** had medical problems listed below?

Eyes	**YES**	**NO**	
Skin	**YES**	**NO**	
Kidneys	**YES**	**NO**	
Lungs	**YES**	**NO**	
Stomach or bowel	**YES**	**NO**	
Nervous system or brain	**YES**	**NO**	

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 had 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**
Do you currently take or have you taken birth control pills in the last 5 years?	**YES**	**NO**

Medications:

Are you allergic to any medications?	**YES**	**NO**
Please list all allergies, including medications: ____		
Please list **ALL EYE DROPS**:		

Drug Name	Dosage	Frequency/eye

Patient Name: ____

Medications: **LIST <u>all Other MEDICATIONS</u>**:

Drug Name	Dosage	Frequency

PAST Medical/Surgical HISTORY:

Please List all **Eye Conditions and Surgeries** with dates:

Eye Medical Condition and Eye Surgeries	Date

Patient Name: ____

Please list all other **Medical History:**

Medical Health Problems	Date

NonEye Surgeries	Date

Patient Name: ______________________________________

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**

Have you ever been told that you have the following conditions?		
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 Nodosa	**YES**	**NO**

Have you ever had any of the following illnesses?

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 had any of the following symptoms in the past year?
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**

Patient Name: ____
Have you had any of the following symptoms in the past year?
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**

Patient Name: ____
Have you had any of the following symptoms in the past year?
RESPIRATORY:

Severe or Frequent Colds	**YES**	**NO**
Constant Coughing	**YES**	**NO**
Coughing Up Blood	**YES**	**NO**
Recent Flu or Viral 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 Easy Bruising	**YES**	**NO**
Frequent or Easy 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**

Patient Name: ____

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

GENITOURINARY:

Kidney Problems	**YES**	**NO**
Bladder Trouble	**YES**	**NO**
Blood in your Urine	**YES**	**NO**
Urinary Discharge	**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**