OAKLAND
OPHTHALMIC
SURGERY, P.C.

## *Ocular Inflammatory Disease Review of Systems Questionnaire*

This is a **confidential** survey. Please respond to all questions by circling the proper answer.

**Patient Name:** _____

**Date of Birth:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Telephone:** _____ **Home:** _____ **Cell:** _____ **Work:** _____

**Email:** _____

**Referring Physician:** _____

**Street Address:** _____

**City:** _____ **State:** _____ **Zip Code:** _____

**Telephone:** _____

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** |

Has anyone in your family had medical problems listed below?

| | | |
|---|---|---|
| **Eyes** | **YES** | **NO** |
| **Skin** | **YES** | **NO** |
| **Kidneys** | **YES** | **NO** |

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| | | |
|---|---|---|
| **Lungs** | **YES** | **NO** |
| **Stomach or Bowel** | **YES** | **NO** |
| **Nervous System or Bowel** | **YES** | **NO** |



SOCIAL HISTORY: Age (Years): _____ Current Job: _____

| | | |
|---|---|---|
| **Have you lived outside of the U.S.A?<br>If yes, where?** | **YES** | **NO** |
| **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 drink untreated stream, well or lake water?** | **YES** | **NO** |
| **Do you smoke cigarettes?** | **YES** | **NO** |
| **Have you ever used intravenous drugs?** | **YES** | **NO** |
| **Have you ever had a bisexual or homosexual relationship?** | **YES** | **NO** |
| **Have you ever taken birth control pills?** | **YES** | **NO** |

PERSONAL MEDICAL HISTORY:

| | | |
|---|---|---|
| **Are you allergic to any medications?<br>If yes, which medications?** | **YES** | **NO** |
| **Please list the medications that you are currently taking, including non-prescription drugs such as aspirin, Advil, antihistamines, etc:** | | |

PAST MEDICAL HISTORY:

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

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Please list all other operations that you have had and the dates of the surgeries.

Has 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** |

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| | | |
|---|---|---|
| **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 Nodosa** | **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 had any of the following symptoms in the past year?

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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** |

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** |

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| | | |
|---|---|---|
| **Severe Itching** | **YES** | **NO** |

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** |

Have you ever had any of the following symptoms?

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** |

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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** |

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** |

_____

Patient Signature

_____ _____

M.D. Signature Date