Retina Associates of Western NY, P.C
Ocular Inflammatory Disease Review of Systems Questionnaire

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

Name: ____

Date of Birth: ______________ **Reason for Visit:** ____________________________

REVIEW OF SYSTEMS

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

GENERAL HEALTH	Circle YES or NO. If YES, please explain		
Fevers (persistent or recurrent)	YES	NO	
Night sweats	YES	NO	
Fatigue (tire easily)	YES	NO	
Poor appetite	YES	NO	
Unexplained weight loss	YES	NO	

HEAD	Circle YES or NO. If YES, please explain		
Frequent or severe headaches	YES	NO	
Numbness or tingling in your body	YES	NO	
Paralysis (the loss of the ability to move) in parts of your body	YES	NO	
Seizures or convulsions	YES	NO	

EARS	Circle YES or NO. If YES, please explain		
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	Circle YES or NO. If YES, please explain		
Sores in your nose or mouth	YES	NO	
Severe or recurrent nosebleeds	YES	NO	
Sinus trouble	YES	NO	
Persistent hoarseness	YES	NO	

SKIN	Circle YES or NO. If YES, please explain		
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 bites	YES	NO	
Painfully cold fingers	YES	NO	
Severe itching	YES	NO	

RESPIRATORY	Circle YES or NO. If YES, please explain		
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	Circle YES or NO. If YES, please explain

Chest pain	YES	NO	
Shortness of breath	YES	NO	

BLOOD	**Circle YES or NO. If YES, please explain**		
Frequent or easy bruising	YES	NO	
Frequent or easy bleeding	YES	NO	
Have you received blood transfusions?	YES	NO	

GASTROINTESTINAL	**Circle YES or NO. If YES, please explain**		
Trouble swallowing	YES	NO	
Diarrhea	YES	NO	
Bloody stools	YES	NO	
Stomach ulcers	YES	NO	
Jaundice or yellow skin	YES	NO	

BONES AND JOINTS	**Circle YES or NO. If YES, please explain**		
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	**Circle YES or NO. If YES, please explain**		
Kidney problems	YES	NO	
Bladder trouble	YES	NO	
Blood in your urine	YES	NO	

Urinary discharge	YES	NO	
Genital sores or ulcers	YES	NO	

OTHER	**Circle YES or NO**		
Are you pregnant?	YES	NO	
Do you plan to be pregnant in the future?	YES	NO	

SOCIAL HISTORY

Current job: ______________________________ Employer: ________________________

Please answer yes or no to the following. If yes, please explain.

Have you lived outside the USA? If so, where?	YES	NO	
Have you traveled outside the USA? If so, 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 had unpasteurized milk or cheese?	YES	NO	
Have you 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	
Do you currently take or have you taken birth control pills in the last 5 years?	YES	NO	

MEDICAL HISTORY

Have you ever been told 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
Pneumonia	YES	NO
Ulcers (nose, mouth, genitals)	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
Lyme Disease	YES	NO
Histoplasmosis	YES	NO
Candida	YES	NO
Coccidiomycosis	YES	NO
Toxoplasmosis	YES	NO
Toxocariasis	YES	NO
Cysticercosis	YES	NO
Whipple's Disease	YES	NO

HIV/AIDS	YES	NO
Allergies	YES	NO
Vasculitis	YES	NO
Arthritis	YES	NO
Rheumatoid Arthritis	YES	NO
Lupus (Systemic Lupus Erythematousus)	YES	NO
Scleroderma	YES	NO
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’ Heterochromic Ididocyclitis	YES	NO
Vogt-Koyanagi-Harada Syndrome	YES	NO

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?	**Circle YES or NO. If YES, please explain**		
Cancer	YES	NO	
Diabetes	YES	NO	

Arthritis	YES	NO	
Tuberculosis	YES	NO	
Sickle Cell Disease or trait	YES	NO	
Lyme Disease	YES	NO	
Autoimmune Disease (e.g. Lupus)	YES	NO	
Inflammatory Bowel Disease	YES	NO	

SEXUAL HISTORY

Do you have sex with men, women, both?		
Have you had unprotected sex in the past year?	YES	NO

MEDICATIONS

Are you allergic to any medications?	YES	NO
Please list all allergies, including medications:		
Please list all eye drops (name, dosage, frequency, and eye):		

Please list all medications below.

Name of Drug/Medication	**Dosage**	**Frequency**

PAST MEDICAL/SURGICAL HISTORY

Eye Conditions and Eye Surgeries	Date

Non-Eye Surgeries	Date

All other medical health problems	Date

Thank you for taking the time to complete this questionnaire.