Janigian Retina Associates

Diseases and Surgery of the Vitreous and Retina
Ocular Inflammatory Diseases

UVEITIS - SPECIFIC HISTORY FORM

Name: _____

Date of Birth: _____

Medical Doctor: _____

This questionnaire is to obtain facts pertinent to your past and present health. Please **ANSWER ALL QUESTIONS, DO NOT LEAVE ANY BLANK.** If you are not sure, guess.

Directions: Please answer each question by circling the appropriate answer either Yes or No.

Family History
(Including maternal and paternal grandparents, uncles, aunts, first cousins, mother, father, sisters and brothers.)

These questions refer to your family, **NOT YOU**. Questions about your own health will appear in a later section.

Has anyone in your family (not including you) had:

Tuberculosis	Yes	No
Arthritis	Yes	No
Severe anemia	Yes	No
High blood pressure	Yes	No
Sugar diabetes	Yes	No
Allergies	Yes	No
Hay fever	Yes	No
Asthma	Yes	No
Hives	Yes	No
Gout	Yes	No
Syphilis	Yes	No

Has anyone your family had medical troubles of the:

Eyes	Yes	No
Skin	Yes	No
Kidneys	Yes	No
Lungs	Yes	No
Intestines	Yes	No
Brain	Yes	No
Any glands	Yes	No

Social History
In what states have you lived? (Please list ages and the number of years in each different state)

_____

_____

Have you ever lived out of the United States?	Yes	No
Do you take any drugs regularly?	Yes	No
Have you ever used IV drugs?	Yes	No
Do you drink alcohol? Yes No How Much _____		
Do you smoke?	Yes	No
Do you or have you ever taken Birth Control Pills?	Yes	No
Have you ever eaten raw meats or hamburgers?	Yes	No
Have you ever had a puppy (less than 3 yrs. of age)?	Yes	No
If so, was it de-wormed?	Yes	No
Have you ever had a kitten (less than 3 yrs. of age)?	Yes	No
If so, was it de-wormed?	Yes	No
As a child did you play in sandboxes frequented by kittens or puppies?	Yes	No

Your Past History

Have you enjoyed good health previously?	Yes	No
Do you suffer from chronic disease?	Yes	No
Have you ever had any of the following conditions:		
Cold sores	Yes	No
Tuberculosis	Yes	No
Pneumonia	Yes	No
Rheumatism	Yes	No
Arthritis	Yes	No
Hay fever	Yes	No
Asthma	Yes	No
Hives	Yes	No
Severe tonsillitis	Yes	No
Streptococcal infection	Yes	No
Severe persistent diarrhea	Yes	No
Severe influenza	Yes	No
Sugar diabetes	Yes	No
Scarlet fever	Yes	No

Skin rashes	Yes	No
Pleurisy	Yes	No
Parasitic infection	Yes	No
Other severe illness	Yes	No
Have you ever had rheumatic fever? If so, did you		
Have any heart or kidney complications?	Yes	No
Have you ever had persistent unexplained fever?	Yes	No
Were you ever treated for severe anemia?	Yes	No
have you ever had, or were you ever treated for syphilis?	Yes	No
Did a doctor ever treat you for a tumor or cancer?	Yes	No
Have you had gonorrhea?	Yes	No
Has your strength been up to par for the last 5 years?	Yes	No
Have you had bleeding from your mouth?	Yes	No
from your nose?	Yes	No
from your lungs?	Yes	No
from your stomach?	Yes	No
from your bowel or rectum?	Yes	No
Do you bruise easily?	Yes	No
Have you been treated with X-rays?	Yes	No
Have you ever had any serious injuries?	Yes	No
Have you ever had a blood transfusion?	Yes	No
Have you had any surgical operations?	Yes	No

If yes, please list them in order of occurrence:

Type of Operation	Date

Allergies:

Penicillin	Yes	No
Sulfa	Yes	No
Latex	Yes	No
Other		

List all of your medications:

_____

_____

_____

_____

_____

_____

_____

Localized Past History

Head

Do you suffer badly from frequent severe headaches?	Yes	No
Do you often have spells of severe dizziness?	Yes	No
Do you frequently feel faint?	Yes	No
Do you have constant numbness or tingling in any part of your body?	Yes	No
Was any part of your body paralyzed?	Yes	No
Have you ever had a fit or convulsion?	Yes	No
Have you ever had a head injury?	Yes	No

Ears

Do you have any constant noises in either ear?	Yes	No
Have you ever had mastoid trouble?	Yes	No
Have you ever had an ear infection?	Yes	No

Nose and Throat

Have you ever had your tonsils or adenoids removed?	Yes	No
Do you have persistent hoarseness?	Yes	No
Are you often troubled with bad spells of sneezing?	Yes	No
Is your nose often stuffed up?	Yes	No
Have you at times had bad nosebleeds?	Yes	No
Do you suffer from a constantly running nose?	Yes	No
Have you had sinus trouble?	Yes	No
Have X-rays been taken of your sinuses?	Yes	No

Dental

Have you had your teeth examined in the past year?	Yes	No
Have you had teeth X-rays in the past year?	Yes	No

Were any teeth found to be abscessed?	Yes	No

Skin

Are you often bothered by severe itching?	Yes	No
Does your skin often break out in a rash?	Yes	No
Are you often troubled with boils?	Yes	No

Respiratory

Do you often catch severe colds?	Yes	No
Do you frequently suffer from heavy chest colds?	Yes	No
Are you troubled with constant coughing?	Yes	No
Have you ever coughed up blood?	Yes	No
Do you cough up any materials?	Yes	No
Have you had a chronic chest condition?	Yes	No
Did you ever live with anyone who had T.B.?	Yes	No
Do you sometimes have severe, soaking sweats at night?	Yes	No
Do you have bouts of chills and fever?	Yes	No

Gastrointestinal

Do you suffer from frequent loose bowel movements?	Yes	No
Have you ever had severe bloody diarrhea?	Yes	No

Biliary System

Have you ever had jaundice (yellow eyes and skin)?	Yes	No
Have you ever had serious liver or gallbladder trouble?	Yes	No
Do you have bilious attacks?	Yes	No

Bones and Joints

Are your joints ever painfully swollen?	Yes	No
Have your joints ever been red in color or hot to the touch?	Yes	No
Do your muscles and joints constantly feel stiff?	Yes	No
Are you troubled with a serious bodily disability?	Yes	No
Do you usually have severe pains in arms or legs?	Yes	No
Do pains in the back make it hard for you to keep up with your work?	Yes	No
Do you have a stiff back?	Yes	No
Do you have stiffness of muscle or joints after inactivity or sleeping?	Yes	No

Genitourinary

Has a doctor ever said you have kidney or bladder disease? Yes No

If yes to the above question, please explain:

_____

_____

Do you have to urinate more often than normal?	Yes	No
Have you ever passed blood in the urine?	Yes	No
Do you have burning or pain when you pass your urine?	Yes	No
Have you ever had a discharge from the penis?	Yes	No

Neuromuscular

Do you have a stiff back in the morning on awakening?	Yes	No
Do you have shooting or lightning pains?	Yes	No
Are you constantly too tired and exhausted even to eat?	Yes	No
Are you frequently ill?	Yes	No
Are you frequently confined to bed by illness?	Yes	No
Are you always in poor health?	Yes	No

Present Illness

What is your height? _____ ft. _____ in.

What is your usual weight? _____ lbs.

Have you lost more than 10 pounds in the last year?	Yes	No
Is this the first time you have had this same type of eye condition?	Yes	No
Has anyone else in your family had this same, or a similar condition?	Yes	No
Have you ever known anyone with a condition similar to yours?	Yes	No

X _____ **X** _____

Patient Signature Date

Credits: *The Uveitis-Specific History Form is based on a form developed by the Francis I. Proctor Foundation.*