Uveitis Questionnaire

Name: ______________________________ **Date:** ____________________

Who referred you: ________________________ **Diagnosis:** ________________

Please circle your responses

What is your main symptom? Pain; light sensitivity; blurred vision; redness; discharge; floaters

When did this start? ____________________ **Previous episodes?** Yes or No

What treatment have you received? Steroid drops; steroid pills; injections; drops for pressure; immunosuppressive medications; surgeries; none

What is your current treatment? ____

Do you feel that your condition is currently active? Yes or No

Family history: Cancer; Diabetes; Allergies; Arthritis; Rheumatism; Sickle Cell

Social History: Pets; Animal Contact; Tick bites; International Travel; Tobacco use; Drug use; Risk for STDs (syphilis, HIV, etc)

Medical Conditions: ____

Allergies to medications: ____

Current medications: ____

General: Fevers; Chills; Fatigue; Poor appetite; Unintentional weight loss; Feel sick in general

Head: Frequent or Severe Headaches; Fainting; Numbness or Tingling; Paralysis; Seizures

Ears: Hearing Loss or Deafness; Ringing or Noises in Your Ears; Ear infections; Painful ear lobes

Nose & Throat: Mouth sores; Nosebleeds; Sinus trouble; Hoarseness; Tooth or gum infections

Skin: Rashes; Tick/insect bites; White Patches of Skin or Hair; Loss of hair; Painfully Cold Fingers

Respiratory: Frequent colds; constant cough; coughing up blood; difficulty breathing

Cardiovascular: Chest pain; shortness of breath; swelling in your legs

Blood: Easy bruising; easy bleeding; history of blood transfusions; history of blood clots

Gastrointestinal: Trouble Swallowing; diarrhea; bloody stools; stomach ulcers; jaundice/yellow skin

Bones and Joints: Stiff joints; morning joint stiffness; swollen joints; stiff lower back; muscle aches

Genitourinary: Kidney problems; bladder trouble; blood in urine; genital sores/ulcers; testicular pain

Are you pregnant? Yes or No or N/A **Do you plan to have children?** Yes or No