

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	

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' Heterochromic Iridocyclitis	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