



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
Lungs	YES	NO
Stomach or Bowel	YES	NO
Nervous System or Bowel	YES	NO

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SOCIAL HISTORY: Age (Years): \_\_\_\_\_ Current Job: \_\_\_\_\_

Have you lived outside of the U.S.A? 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? 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.

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Has you ever been told that you have the following conditions?

<b>Anemia (Low Blood Counts)</b>	<b>YES</b>	<b>NO</b>
<b>Cancer</b>	<b>YES</b>	<b>NO</b>
<b>Diabetes</b>	<b>YES</b>	<b>NO</b>
<b>Hepatitis</b>	<b>YES</b>	<b>NO</b>
<b>High Blood Pressure</b>	<b>YES</b>	<b>NO</b>
<b>Pleurisy</b>	<b>YES</b>	<b>NO</b>
<b>Pneumonia</b>	<b>YES</b>	<b>NO</b>
<b>Ulcers</b>	<b>YES</b>	<b>NO</b>
<b>Herpes (Cold Sores)</b>	<b>YES</b>	<b>NO</b>
<b>Chicken Pox</b>	<b>YES</b>	<b>NO</b>
<b>Shingles (Zoster)</b>	<b>YES</b>	<b>NO</b>
<b>German Measles (Rubella)</b>	<b>YES</b>	<b>NO</b>
<b>Measles (Rubeola)</b>	<b>YES</b>	<b>NO</b>
<b>Mumps</b>	<b>YES</b>	<b>NO</b>
<b>Chlamydia or Trachoma</b>	<b>YES</b>	<b>NO</b>
<b>Syphilis</b>	<b>YES</b>	<b>NO</b>
<b>Gonorrhea</b>	<b>YES</b>	<b>NO</b>
<b>Any other Sexually Transmitted Disease</b>	<b>YES</b>	<b>NO</b>
<b>Tuberculosis (TB)</b>	<b>YES</b>	<b>NO</b>
<b>Leprosy</b>	<b>YES</b>	<b>NO</b>
<b>Leptospirosis</b>	<b>YES</b>	<b>NO</b>
<b>Lyme Disease</b>	<b>YES</b>	<b>NO</b>
<b>Histoplasmosis</b>	<b>YES</b>	<b>NO</b>
<b>Candida or Moniliasis</b>	<b>YES</b>	<b>NO</b>
<b>Coccidiomycosis</b>	<b>YES</b>	<b>NO</b>
<b>Sporotrichosis</b>	<b>YES</b>	<b>NO</b>
<b>Toxoplasmosis</b>	<b>YES</b>	<b>NO</b>
<b>Toxocariasis</b>	<b>YES</b>	<b>NO</b>
<b>Cysticercosis</b>	<b>YES</b>	<b>NO</b>
<b>Trichinosis</b>	<b>YES</b>	<b>NO</b>
<b>Whipple's Disease</b>	<b>YES</b>	<b>NO</b>
<b>AIDS</b>	<b>YES</b>	<b>NO</b>
<b>Hay Fever</b>	<b>YES</b>	<b>NO</b>
<b>Allergies</b>	<b>YES</b>	<b>NO</b>
<b>Vasculitis</b>	<b>YES</b>	<b>NO</b>
<b>Arthritis</b>	<b>YES</b>	<b>NO</b>
<b>Rheumatoid Arthritis</b>	<b>YES</b>	<b>NO</b>
<b>Lupus (Systemic Lupus Erythematosus)</b>	<b>YES</b>	<b>NO</b>
<b>Scleroderma</b>	<b>YES</b>	<b>NO</b>

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Have you ever had any of the following illnesses?

<b>Reiter's Syndrome</b>	<b>YES</b>	<b>NO</b>
<b>Colitis</b>	<b>YES</b>	<b>NO</b>
<b>Crohn's Disease</b>	<b>YES</b>	<b>NO</b>
<b>Ulcerative Colitis</b>	<b>YES</b>	<b>NO</b>
<b>Behcet's Disease</b>	<b>YES</b>	<b>NO</b>
<b>Sarcoidosis</b>	<b>YES</b>	<b>NO</b>
<b>Ankylosing Spondylitis</b>	<b>YES</b>	<b>NO</b>
<b>Erythema Nodosa</b>	<b>YES</b>	<b>NO</b>
<b>Temporal Arteritis</b>	<b>YES</b>	<b>NO</b>
<b>Multiple Sclerosis</b>	<b>YES</b>	<b>NO</b>
<b>Serpiginous Choroidopathy</b>	<b>YES</b>	<b>NO</b>
<b>Fuchs' Heterochromic Iridocyclitis</b>	<b>YES</b>	<b>NO</b>
<b>Vogt-Koyanagi-Harada Syndrome</b>	<b>YES</b>	<b>NO</b>

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

**GENERAL HEALTH:**

<b>Chills</b>	<b>YES</b>	<b>NO</b>
<b>Fevers (Persistent or Recurrent)</b>	<b>YES</b>	<b>NO</b>
<b>Night Sweats</b>	<b>YES</b>	<b>NO</b>
<b>Fatigue (Tire Easily)</b>	<b>YES</b>	<b>NO</b>
<b>Poor Appetite</b>	<b>YES</b>	<b>NO</b>
<b>Unexplained Weight Loss</b>	<b>YES</b>	<b>NO</b>
<b>Do you Feel Sick</b>	<b>YES</b>	<b>NO</b>

**HEAD:**

<b>Frequent or Severe Headaches</b>	<b>YES</b>	<b>NO</b>
<b>Fainting</b>	<b>YES</b>	<b>NO</b>
<b>Numbness or Tingling in your body</b>	<b>YES</b>	<b>NO</b>
<b>Paralysis in parts of your body</b>	<b>YES</b>	<b>NO</b>
<b>Seizures or Convulsions</b>	<b>YES</b>	<b>NO</b>

**EARS:**

<b>Hard of Hearing or Deafness</b>	<b>YES</b>	<b>NO</b>
<b>Ringling or Noises in Your Ears</b>	<b>YES</b>	<b>NO</b>
<b>Frequent or Severe Ear Infections</b>	<b>YES</b>	<b>NO</b>
<b>Painful or Swollen Ear Lobes</b>	<b>YES</b>	<b>NO</b>

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**NOSE AND THROAT:**

<b>Sores in Your Nose or Mouth</b>	<b>YES</b>	<b>NO</b>
<b>Severe or Recurrent Nosebleeds</b>	<b>YES</b>	<b>NO</b>
<b>Frequent Sneezing</b>	<b>YES</b>	<b>NO</b>
<b>Sinus Trouble</b>	<b>YES</b>	<b>NO</b>
<b>Persistent Hoarseness</b>	<b>YES</b>	<b>NO</b>
<b>Tooth or Gum Infections</b>	<b>YES</b>	<b>NO</b>

**SKIN:**

<b>Rashes</b>	<b>YES</b>	<b>NO</b>
<b>Skin Sores</b>	<b>YES</b>	<b>NO</b>
<b>Sunburn Easily (Photosensitivity)</b>	<b>YES</b>	<b>NO</b>
<b>White Patches of Skin or Hair</b>	<b>YES</b>	<b>NO</b>
<b>Loss of Hair</b>	<b>YES</b>	<b>NO</b>
<b>Tick or Insect Bites</b>	<b>YES</b>	<b>NO</b>
<b>Painfully Cold Fingers</b>	<b>YES</b>	<b>NO</b>
<b>Severe Itching</b>	<b>YES</b>	<b>NO</b>

**RESPIRATORY:**

<b>Severe or Frequent Colds</b>	<b>YES</b>	<b>NO</b>
<b>Constant Coughing</b>	<b>YES</b>	<b>NO</b>
<b>Coughing Up Blood</b>	<b>YES</b>	<b>NO</b>
<b>Recent Flu or Viral Infection</b>	<b>YES</b>	<b>NO</b>
<b>Wheezing or Asthma Attacks</b>	<b>YES</b>	<b>NO</b>
<b>Difficulty Breathing</b>	<b>YES</b>	<b>NO</b>

Have you ever had any of the following symptoms?

**CARDIOVASCULAR:**

<b>Chest Pain</b>	<b>YES</b>	<b>NO</b>
<b>Shortness of Breath</b>	<b>YES</b>	<b>NO</b>
<b>Swelling of your Legs</b>	<b>YES</b>	<b>NO</b>

**BLOOD:**

<b>Frequent or Easy Bruising</b>	<b>YES</b>	<b>NO</b>
<b>Frequent or Easy Bleeding</b>	<b>YES</b>	<b>NO</b>
<b>Have you Received Blood Transfusions</b>	<b>YES</b>	<b>NO</b>

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**GASTROINTESTINAL:**

<b>Trouble Swallowing</b>	<b>YES</b>	<b>NO</b>
<b>Diarrhea</b>	<b>YES</b>	<b>NO</b>
<b>Bloody Stools</b>	<b>YES</b>	<b>NO</b>
<b>Stomach Ulcers</b>	<b>YES</b>	<b>NO</b>
<b>Jaundice or Yellow Skin</b>	<b>YES</b>	<b>NO</b>

**BONES AND JOINTS:**

<b>Stiff Joints</b>	<b>YES</b>	<b>NO</b>
<b>Painful or Swollen Joints</b>	<b>YES</b>	<b>NO</b>
<b>Stiff Lower Back</b>	<b>YES</b>	<b>NO</b>
<b>Back Pain while Sleeping or Awakening</b>	<b>YES</b>	<b>NO</b>
<b>Muscle Aches</b>	<b>YES</b>	<b>NO</b>

**GENITOURINARY:**

<b>Kidney Problems</b>	<b>YES</b>	<b>NO</b>
<b>Bladder Trouble</b>	<b>YES</b>	<b>NO</b>
<b>Blood in your Urine</b>	<b>YES</b>	<b>NO</b>
<b>Urinary Discharge</b>	<b>YES</b>	<b>NO</b>
<b>Genital Sores or Ulcers</b>	<b>YES</b>	<b>NO</b>
<b>Prostatitis</b>	<b>YES</b>	<b>NO</b>
<b>Testicular Pain</b>	<b>YES</b>	<b>NO</b>

**OTHER:**

<b>Are you Pregnant?</b>	<b>YES</b>	<b>NO</b>
<b>Do you Plan to be Pregnant in the Future?</b>	<b>YES</b>	<b>NO</b>

\_\_\_\_\_  
M.D. Signature

\_\_\_\_\_  
Date