Retina Consultants of Carolina, PA

Confidential Patient History – Uveitis Addendum

Patient Name

Appointment Date

Uveitis, or inflammation of the eye, may be associated with a wide variety of conditions. Please answer the following as completely as possible.

OCULAR HISTORY

How long have you had uveitis?

How old were you when it was diagnosed? _____ By what doctor? _____

Does anyone else in your family have a similar eye problem?

Disease Pattern: Check the description that applies best to your eye problem:

Duration:

 This is the 1 st episode of problem and it has lasted less than 6 weeks
Problem present all the timelonger than 6 weeks (How long?)
 Problem comes and goes (How many episodes per year?)
 Other

Unilateral/Bilateral:

- _____ Only one eye ever affected (Circle one: Right / Left)
- _____ Both eyes have been affected, but only one at a time
- _____ Both eyes may be affected at same time

Symptoms: (Please check the appropriate column)

RIGHT EYE		LEFT EYE
	Pain	
	Sensitivity to Light	
	Eye Redness	
	Floaters	
	Blurred Vision	

Name any tasks you are unable to do because of blurred vision:

			Have you ever been treated with any of the following? (Please check all that apply)							
Steroids: Pills (e.g., Prednisone)Eye Drops (e.g., Pred Forte, Durezol) Injections in or around eye Intravenous										
	Yes	No		Yes	No					
Cyclophosphamide (Cytoxan)	Yes	No	Cyclosporine A (Sandimmune)	Yes	No					
Cyclophosphamide (Cytoxan) Humira	Yes	No	Cyclosporine A (Sandimmune) Azathioprine (Imuran)	Yes	No					

List any medication side effects you have had: _____

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SOCIAL HISTORY

Birthplace:		
Other places you have lived:		
Places outside the United States you have traveled:		
	Yes	No
Have you ever owned a dog?		
Have you ever owned a cat?		
Have you been exposed to sick animals?		
Have you had tick bites, or severe insect bites?		
Do you drink untreated stream, well or lake water, or have you		
gone hunting or camping?		
Have you ever eaten raw meat?		
Have you ever had unpasteurized milk or cheese?		
Do you smoke cigarettes?		
Have you ever had a blood transfusion?		
Have you ever used recreational intravenous drugs?		
Have you ever had a bisexual or homosexual relationship?		
For Women: Are you pregnant or breastfeeding?		
Do you plan to become pregnant in the near future?		

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Family History: These refer to grandparents, parents, aunts, uncles, brothers, sister, children					
To your knowledge, has anyone in your family ever had one of the following?					
	Yes	No			
Uveitis, or inflammation in the eye					
Arthritis or rheumatism					
Sickle cell disease or trait					
Syphilis					
Tuberculosis					

PERSONAL MEDICAL HISTORY

Have you ever had?	Yes	No	Have you ever had?	Yes	No
Chicken Pox			Cancer		
Chlamydia or Trachoma			Sarcoidosis		
Syphilis			Shingles (Zoster)		
Gonorrhea			Herpes (cold sores)		
Toxoplasmosis			AIDS		
Behcet's Disease			Histoplasmosis		
Measles			Cysticercosis		
Tuberculosis			Trichinosis		
Lyme Disease			Toxocariasis		
Vasculitis			Arthritis		
Lupus			Ankylosing Spondylitis		
Temporal Arteritis			Multiple Sclerosis		
Erythema Nodosa			Colitis or Crohn's disease		
Anemia			Hepatitis		

Have you had symptoms of:	Yes	No	Have you had symptoms of:	Yes	No
Persistent/recurrent: Chills			Rashes		
Fevers			Skin sores		
Night sweats			Skin lumps or nodules		
Severe fatigue (tire easily)			Light patches of skin or hair		
Poor appetite			Loss of clumps of hair		
Unexplained weight loss			Psoriasis		
Frequent/severe headaches			Constant coughing		
Fainting or Severe dizziness			Recent flu or viral infection		
Numbness or tingling			Difficulty in breathing		
Paralysis or Weakness			Frequent or easy bruising		
Seizures or Convulsions			Frequent or easy bleeding		
Psychiatric Conditions			Stomach ulcers		
Hearing Loss			Severe/persistent diarrhea		
Ringing or noises in ears			Jaundice or yellow skin		
Painful or swollen ear lobes			Stiff back or joints		
Frequent ear infections			Kidney problems		
Swollen glands			Painful or swollen joints		
Mouth ulcers			Discharge from penis/vagina		
Trouble swallowing			Genital sores or ulcers		

(For Office Use Only)

UVEITIS LAB RESULTS

Date/Result
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PT NAME

Imaging Imaging Chest X-Ray – PA & Lateral Imaging Chest CT Imaging Sacroiliac joint X-ray Imaging MRI Brain & Orbits w & w/o contrast Imaging <i>URINALYSIS</i> Imaging Routine Imaging Urine B2 microglobulin Imaging	
Chest X-Ray – PA & Lateral Chest CT Sacroiliac joint X-ray MRI Brain & Orbits w & w/o contrast URINALYSIS Routine Creatinine Clearance	
Chest CT Sacroiliac joint X-ray MRI Brain & Orbits w & w/o contrast URINALYSIS Routine Creatinine Clearance	
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URINALYSIS Routine Creatinine Clearance	
Routine Creatinine Clearance	
Routine Creatinine Clearance	
Urine B2 microglobulin	
PCR - Aqueous	
HSV VZV	
CMV	
Toxoplasmosis	
Bartonella	
Bartonolia	
PCR - Vitreous	
HSV	
VZV	
CMV	
Toxoplasmosis	
Bartonella	
Cultures - Aqueous	
Routine	
Fungal	
AFB	
Cultures - Vitreous	
Routine	
Fungal	
AFB	
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Biopsy	
Conjunctiva	
Vitreous	
Retina	