Midwest Eye Institute

OCULAR INFLAMMATION QUESTIONNAIRE
for the patients of ***RAJ K. MATURI, M.D.***

Patient Name: _____ DATE: _____

Date of birth: _____ Referring Doctor: _____

SOCIAL HISTORY:

1. Have you ever lived outside of the United States? YES NO
   If Yes, where? _____
2. Have you ever owned a dog or a cat? YES NO
3. Any dog bites or cat/kitten scratches ever? YES NO
4. Have you ever been exposed to sick animals? YES NO
5. Have you ever eaten raw or uncooked meat? YES NO
6. Have you ever eaten unpasteurized milk or cheese? YES NO
7. Have you drunk untreated well, lake or stream water? YES NO
8. Have you smoked cigarettes? YES NO
   IF YES, Packs/day_____, How many years? ____
   Quit Date_____, or still smoking (circle)
9. Have you ever used intravenous drugs? YES NO
10. Have you had a bisexual or homosexual relationship? YES NO

(Next four questions are for females)Males, continue on to next page…

11. Have you ever taken birth control pills? YES NO
12. Are you pregnant? YES NO
13. Do you plan to get pregnant in the future? YES NO
14. Have you had your "tubes tied" or had a hysterectomy YES NO

Thank you for the time taken to fill this form. Sincerely, Raj K. Maturi, M.D.

Have you had any of the following symptoms in the past <u>ONE year</u>?
(If Yes, please circle symptom)

<u>GENERAL HEALTH:</u> chills, fevers (persisent or recurrent), night sweats, fatigue, poor appetite, unexplained weight loss.

<u>HEAD:</u> headaches (frequent or severe), fainting, numbness or tingling in body, paralysis in part of body, seizures, convulsions.

<u>EARS:</u> hard of hearing or deafness, ringing or noises in ears, frequent or severe ear infections, painful or swollen ear lobes.

<u>NOSE AND THROAT:</u> sores in nose or mouth, severe or recurrent nosebleeds, frequent sneezing, sinus trouble, persistent hoarseness, tooth or gum infections.

<u>SKIN:</u> rashes, skin sores, sunburn easily, white patches of skin or hair, hair loss, tick or insect bites, painfully cold fingers, severe itching.

<u>RESPIRATORY:</u> severe or frequent colds, constant coughing, coughing blood, recent flu or viral infection, wheezing or asthma attacks, difficulty breathing.

<u>CARDIOVASCULAR:</u> chest pain, shortness of breath, leg swelling.

<u>BLOOD:</u> frequent or easy bruising, frequent or easy bleeding, blood transfusions.

<u>GASTROINTESTINAL:</u> trouble swallowing, diarrhea, bloody stools, stomach ulcers, jaundice or yellow skin.

<u>BONES AND JOINTS:</u> stiff joints, painful or swollen joints, stiff lower back, back pain while sleeping or awakening, muscle aches.

<u>GENITOURINARY:</u> kidney problems, bladder trouble, blood in urine, urinary discharge, genital sores or ulcers, prostatitis, testicular pain.

Work History:
Current Occupation: _____

Have you worked in any hazardous locations or with toxic chemicals? YES NO
If YES, please explain:

Pt Name: _____ Date of Birth: _____

Have you ever been diagnosed with any of the following conditions?
(Please circle YES or NO)

Anemia	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	Mumps	YES	NO
German Measles (rubella)	YES	NO	HIV/AIDS	YES	NO
Measles (rubeola)	YES	NO	Syphilis	YES	NO
Chlamydia or Trachoma	YES	NO	Gonorrhea	YES	NO
Tuberculosis	YES	NO	Leprosy	YES	NO
Leptospirosis	YES	NO	Lyme Disease	YES	NO
Histoplasmosis	YES	NO	Sporotrichosis	YES	NO
Candida or Moniliasis	YES	NO	Coccidiomycosis	YES	NO
Toxoplasmosis	YES	NO	Toxocariasis	YES	NO
Cysticercosis	YES	NO	Trichinosis	YES	NO
Whipple's Disease	YES	NO	Hay Fever	YES	NO
Allergies	YES	NO	Vasculitis	YES	NO
Arthritis	YES	NO	Lupus	YES	NO
Rheumatoid Arthritis	YES	NO	Scleroderma	YES	NO

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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
Temporal Arteritis	YES	NO	Multiple Sclerosis	YES	NO

Serpiginous Choroidopathy YES NO

Fuchs' Heterochoromic Ididocyclitis YES NO

Vogt-Koyanagi-Harada Syndrome YES NO

Other Sexually Transmitted Disease: YES NO

Any other information that you would like us to have: _____

_____

FAMILY HISTORY: These questions refer to your parents, siblings, children, grandparents, aunts, uncles or grandchildren.

Has anyone in your family had any of the following conditions or problems?

Cancer	YES	NO	Diabetes	YES	NO
Allergies	YES	NO	Syphilis	YES	NO
Arthritis/ Rheumatism	YES	NO	Tuberculosis	YES	NO
Sickle cell dz /trait	YES	NO	Lyme Disease	YES	NO
Gout	YES	NO	Lung problem	YES	NO
Eye problem	YES	NO	Skin problem	YES	NO
Kidney problem	YES	NO	Stomach/ Bowel Problem	YES	NO
Nervous system/ Brain problem	YES	NO			

Thank you for the time taken to fill this form. Sincerely, Raj K. Maturi, M.D.