

ACES Pediatric Eye UVEITIS SURVEY

Background: Uveitis is an inflammation of part of the eye which normally has blood vessels. This includes the iris (iritis), ciliary body (cyclitis) and the choroid (chorioretinitis). We may never be possible to identify the exact cause of uveitis in some patients (idiopathic uveitis). However, many case of uveitis are caused by infections or diseases around the eye or from the rest of the body. To help your eyes, and the rest of your health, please fill out this form as carefully as possible.

Patient Name: _____ ACES# _____

Date of first survey: ____/____/____ Subsequent Dates (*Different pen color*)

Family History: (*please check diseases from which your relatives have suffered*)

- cancer diabetes allergies arthritis syphilis
 tuberculosis Sickle-cell Lyme Disease

Major medical problems *your family or relatives* have had with the:

- eyes skin kidneys lungs stomach or bowel
 nervous system

Social History: (*check all those which apply to you*)

Your age: _____ years. Current job: _____

- I have lived outside the U.S.? Where: _____
 My family has owned a dog?
 My family has owned a cat?
 I have eaten raw meat or uncooked sausage?
 I have been exposed to sick animals?
 I have ingested untreated stream, lake or well water?
 I have smoked cigarettes? How many years? _____
 I regularly consume alcoholic beverages? How many per day?
 I have used non-prescribed intravenous drugs?
 I have taken birth control pills?
 I have had a bisexual or homosexual relationship?

PERSONAL MEDICAL HISTORY

- I have allergies to medications? Which ones?: _____
 I have recently taken prescription medications? Which ones?
 I have recently taken non-prescription medications?: Which ones?
 I have recently taken vitamins or nutritional supplements? Which?

Medical History

Please list all eye operations or laser surgery you have had with dates:

Please list all eye injuries you have suffered. Include dates:

Adapted from: Nussenblatt R, Whitcup S, Palestine A: Uveitis Fundamentals and clinical practice, Second edition. St. Louis, Mosby, 1996

Please turn over and complete other page.

*** Uveitis- associated Illnesses: (*Please check all which apply to you*) ***

- | | | |
|---|--|---|
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Lyme Disease | <input type="checkbox"/> Juvenile Rheumatoid Arthritis |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Histoplasmosis | <input type="checkbox"/> Lupus |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Candidiasis or moniliasis | <input type="checkbox"/> Scleroderma |
| <input type="checkbox"/> High blood Pressure | <input type="checkbox"/> Coccidiomycosis | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Sporotrichosis | <input type="checkbox"/> Reiter's syndrome |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cryptococcal infection | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Toxoplasmosis | <input type="checkbox"/> Crohn's Disease |
| <input type="checkbox"/> Herpes (Cold sores) | <input type="checkbox"/> Amoeba infection | <input type="checkbox"/> Ulcerative colitis |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Giardiasis | <input type="checkbox"/> Behçet's disease |
| <input type="checkbox"/> Shingles (zoster) | <input type="checkbox"/> Toxocariasis | <input type="checkbox"/> Sarcoidosis |
| <input type="checkbox"/> German measles (rubella) | <input type="checkbox"/> Cysticercosis | <input type="checkbox"/> Ankylosing spondylitis |
| <input type="checkbox"/> Measles (rubeola) | <input type="checkbox"/> Trichinosis | <input type="checkbox"/> Erythema nodosum |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Whipple's Disease | <input type="checkbox"/> Temporal arteritis |
| <input type="checkbox"/> Chlamydia or trachoma | <input type="checkbox"/> AIDS | <input type="checkbox"/> Multiple scleritis |
| <input type="checkbox"/> Syphilis | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Serpiginous choroidopathy |
| <input type="checkbox"/> Any other sexually disease | <input type="checkbox"/> Allergies | <input type="checkbox"/> Fuchs' heterochromic iridocyclitis |
| <input type="checkbox"/> Leprosy | <input type="checkbox"/> Vasculitis | <input type="checkbox"/> Vogt-Koyanagi-Harada syndrome |
| <input type="checkbox"/> Leptospirosis | <input type="checkbox"/> Arthritis | |
| | <input type="checkbox"/> Rheumatoid Arthritis | |

*** Symptoms associated with Uveitis: (*Please check all which apply to you*) ***

- | | | |
|--|--|---|
| <input type="checkbox"/> Chills | <input type="checkbox"/> Tooth or gum infections | <input type="checkbox"/> Trouble swallowing |
| <input type="checkbox"/> Fevers (persistent/recurrent) | <input type="checkbox"/> Skin sores | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Rashes | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Sunburn easily | <input type="checkbox"/> Stomach ulcers |
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> White patches of hair or skin | <input type="checkbox"/> Jaundice or yellow skin |
| <input type="checkbox"/> Unexplained weight loss | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Stiff joints |
| <input type="checkbox"/> Do you feel sick? | <input type="checkbox"/> Tick or severe insect bites | <input type="checkbox"/> Painful or swollen joints |
| <input type="checkbox"/> Frequent / severe headaches | <input type="checkbox"/> Painfully cold fingers | <input type="checkbox"/> Stiff lower back |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Severe itching | <input type="checkbox"/> Back pain sleeping / awakening |
| <input type="checkbox"/> Numbness or Tingling | <input type="checkbox"/> Severe or frequent colds | <input type="checkbox"/> Muscle aches |
| <input type="checkbox"/> Paralysis or weakness | <input type="checkbox"/> Constant coughing | <input type="checkbox"/> Kidney problems |
| <input type="checkbox"/> Seizures or convulsions | <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Bladder trouble |
| <input type="checkbox"/> Psychiatric conditions | <input type="checkbox"/> Recent flu or viral infection | <input type="checkbox"/> Blood in urine |
| <input type="checkbox"/> Hard of hearing or deafness | <input type="checkbox"/> Wheezing or asthma attacks | <input type="checkbox"/> Urinary discharge |
| <input type="checkbox"/> Ringing or noises in ears | <input type="checkbox"/> Difficulty breathing | <input type="checkbox"/> Genital sores or ulcers |
| <input type="checkbox"/> Frequent/severe ear infection | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Prostatitis |
| <input type="checkbox"/> Painful or swollen ear lobes | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Testicular pain |
| <input type="checkbox"/> Sores in nose or mouth | <input type="checkbox"/> Swelling of legs | <input type="checkbox"/> Are you pregnant? |
| <input type="checkbox"/> Severe / frequent nosebleeds | <input type="checkbox"/> Frequent or easy bruising | <input type="checkbox"/> Plan a pregnancy soon? |
| <input type="checkbox"/> Frequent sneezing | <input type="checkbox"/> Frequent or easy bleeding | |
| <input type="checkbox"/> Sinus trouble | <input type="checkbox"/> Had blood transfusions | |
| <input type="checkbox"/> Persistent hoarseness | | |

Thank You!