Tampa Bay Uveitis Center, LLC
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INSTRUCTIONS: Answer all of the questions by checking the appropriate response or filling in the requested information.

Date:_____ Signature:

Patient Name:_____

Address:_____

_____

Phone Numbers (include area code):

(H)_____ (W)_____

Referring Physician Name:_____

And Phone Number:_____

FAMILY HISTORY

Please √ whether anyone in **YOUR FAMILY** has had:

	Yes	No
Cancer	☐	☐
Diabetes	☐	☐
Allergies	☐	☐
Arthritis or rheumatism	☐	☐
Syphilis	☐	☐
Tuberculosis	☐	☐
Sickle cell disease or trait	☐	☐
Lyme disease	☐	☐

Has anyone in **YOUR FAMILY** had medical problems of the:

	Yes	No
Eyes	☐	☐
Skin	☐	☐
Kidneys	☐	☐
Lungs	☐	☐
Stomach or bowel	☐	☐
Nervous system or brain	☐	☐

SOCIAL HISTORY

Age (Years)_____ Occupation:_____

If you have lived outside of the U.S., where have you lived?_____

	Yes	No
Have you ever owned a dog?	☐	☐
Have you every owned a cat?	☐	☐
Have you ever eaten raw meat or uncooked sausage?	☐	☐
Have you ever been exposed to sick animals?	☐	☐
Do you drink untreated stream, well or lake water?	☐	☐
Do you smoke cigarettes? If yes how much and how long	☐	☐
Do you drink alcohol? If yes how much per day	☐	☐
Have you ever used intravenous drugs?	☐	☐
Have you ever had a bisexual or homosexual relationship?	☐	☐

MEDICAL HISTORY

Have **YOU** ever had any of the following illnesses?

	Yes	No		Yes	No
Cancer	☐	☐	Candida or Moniliasis	☐	☐
Diabetes	☐	☐	Coccidiomycosis	☐	☐
Hepatitis	☐	☐	Sporotrichosis	☐	☐
High Blood Pressure	☐	☐	Cryptococcal Infection	☐	☐
Anemia (Low Blood Count)	☐	☐	Toxoplasmosis	☐	☐
Pneumonia or Pleurisy	☐	☐	Amoeba Infection	☐	☐
Tuberculosis	☐	☐	Giardiasis	☐	☐
Herpes (Cold Sores)	☐	☐	Toxocariasis	☐	☐
Shingles (Zoster)	☐	☐	Cysticercosis	☐	☐
German Measles (Rubella)	☐	☐	Trichinosis	☐	☐
Measles (Rubeola)	☐	☐	Whipple's Disease	☐	☐
Mumps	☐	☐	AIDS	☐	☐
Chlamydia or Trachoma	☐	☐	Hay Fever	☐	☐
Syphilis	☐	☐	Allergies	☐	☐
Other Sexually Transmitted Diseases	☐	☐	Vasculitis	☐	☐
Leprosy	☐	☐	Rheumatoid Arthritis	☐	☐
Leptospirosis	☐	☐	Lupus (Systemic Lupus Erythematosis	☐	☐
Lyme Disease	☐	☐	Scleroderma	☐	☐
Histoplasmosis	☐	☐	Sarcoidosis	☐	☐
Are you allergic to any drugs?	☐	☐	Continued on last page		

REVIEW OF SYSTEMS

Are you currently any of the following symptoms? Answer Y or N

CONSTITUTIONAL

Chills	
Fevers	
Night Sweats	
Fatigue (Tire Easily)	
Poor Appetite	
Unexplained Weight Loss	

NEUROLOGIC

Frequent or Severe Headaches	
Weakness	
Numbness	
Paralysis	
Paresthesia (tingling)	
Neck Stiffness	

EARS / NOSE / THROAT

Hard of hearing or Deafness	
Ringing or Noises in Your Ears	
Painful or Swollen Ear Lobes	
Sores in Your Mouth	
Sinus Trouble	

INTEGUMENT

Rashes	
Skin Sores	
Sunburn Easily (Photosensitivity)	
White Patches of Skin or Hair (Vitiligo or Poliosis)	
Loss of Hair	
Tick or Insect Bites	
Painfully Cold Fingers	

RESPIRATORY

Constant Coughing	
Recent Flu or Viral Infection	

CARDIOVASCULAR

Chest Pain	
Shortness of Breath	
Swelling of Your Legs	

BLOOD / LYMPHATIC

Frequent or Easy Bruising	
Frequent or Easy Bleeding	
Have You Received Blood Transfusions?	

GASTROINTESTINAL

Diarrhea	

Bloody Stools	
Stomach Ulcers	
Jaundice or Yellow Skin	

MUSCULOSKELETAL

Painful Joints	
Swollen Joints	
Stiff Lower Back	
Muscle Aches	

GENITOURINARY

Kidney Problems	
Bladder Trouble	
Blood in Your Urine	
Urinary Discharge	
Genital Sores or Ulcers	

Psychiatric

Problems with Anxiety?	Problems with Depression?

ALLERGIES

Drugs	Reactions

MEDICATIONS

DRUG	Dosage(mg)	Frequency

Ocular Medications

Name of Drop	Which Eye	Dosage