FAMILY HISTORY

These questions refer to your parents, brothers, sisters, children, grandparents, aunts, uncles, and grandchildren.

Has ***anyone in your family*** ever had any of the following?

Cancer	Yes	No
Diabetes	Yes	No
Allergies	Yes	No
Arthritis	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 any of the medical problems below?

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

SOCIAL HISTORY

Age: _____ (years)   Current job: ___________________________________

Have you ever lived outside of US?	Yes	No
If yes, where?		
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 had 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 bisexual or homosexual relationships?	Yes	No
Have you ever taken birth control pills?	Yes	No

PERSONAL MEDICAL HISTORY

Are allergic to any medications?	Yes	No

Please list the names and dates of all of the eye surgeries (including laser surgery) you have had in the past:

___

Please list the names and the dates of all of the surgeries you have had in the past:

___

Have ***you*** ever been told that you have any of the following conditions:

Anemia (low blood count)	Yes	No
Cancer	Yes	No
Diabetes	Yes	No
Hepatitis	Yes	No
High Blood Pressure	Yes	No
Pneumonia or Pleurisy	Yes	No
Tuberculosis	Yes	No
Herpes (cold sores), herpetic ulcers	Yes	No
Chicken pox	Yes	No
Shingles (zoster)	Yes	No
German measles (rubella)	Yes	No
Measles (rubeola)	Yes	No
Mumps	Yes	No
Chlamydia or trachoma	Yes	No
Syphilis	Yes	No
Any sexually transmitted disease	Yes	No
Leprosy	Yes	No
Leptospirosis	Yes	No
Lyme disease	Yes	No
Histoplasmosis	Yes	No
Candidiasis or moniliasis	Yes	No
Coccidioidomycosis	Yes	No
Sporotrichosis	Yes	No

Cryptococcal infection	Yes	No
Toxoplasmosis	Yes	No
Amoeba infection	Yes	No
Giardiasis	Yes	No
Toxocariasis	Yes	No
Cysticercosis	Yes	No
Trichinosis	Yes	No
Whipple’s disease	Yes	No
AIDS	Yes	No
Hay fever	Yes	No
Allergies	Yes	No
Vasculitis	Yes	No
Arthritis	Yes	No
Rheumatoid arthritis	Yes	No
Lupus (Systemic Lupus Erythematosus)	Yes	No
Scleroderma	Yes	No
Reiter’s Syndrome	Yes	No
Colitis	Yes	No
Ulcers	Yes	No
Crohn’s disease	Yes	No
Ulcerative colitis	Yes	No
Behcet’s disease	Yes	No
Sarcoidosis	Yes	No
Ankylosing spondylitis	Yes	No

Erythema nodosum	Yes	No
Temporal arteritis	Yes	No
Multiple sclerosis	Yes	No
Serpiginous choroidopathy	Yes	No
Fuchs’ heterochromic iridocyclitis	Yes	No
Vogt-Koyanagi-Harada (VKH) syndrome	Yes	No

GENERAL HEALTH

Chills	Yes	No
Fevers (persistent or recurrent)	Yes	No
Night sweats	Yes	No
Fatigue	Yes	No
Poor appetite	Yes	No
Unexplained weight loss	Yes	No
Do you feel sick?	Yes	No

NEUROLOGIC

Frequent or severe headaches	Yes	No
Fainting	Yes	No
Numbness or tingling in your body	Yes	No
Paralysis or weakness in parts of your body	Yes	No
Seizure or convulsion	Yes	No
Psychiatric conditions	Yes	No

Ears

Hard of hearing or deafness	Yes	No
Ringing or noises in your ears	Yes	No
Frequent or severe ear infections	Yes	No
Painful or swollen ear lobes	Yes	No

Nose and Throat

Sores in your nose or mouth	Yes	No
Severe or recurrent nose bleeds	Yes	No
Frequent sneezing	Yes	No
Sinus trouble	Yes	No
Persistent hoarseness	Yes	No
Tooth or gum infections	Yes	No

Skin

Rashes	Yes	No
Skin sores	Yes	No
Sunburn easily (photosensitivity)	Yes	No
White patches of skin or hair (vitiligo or poliosis)	Yes	No
Loss of hair	Yes	No
Tick or severe insect bites	Yes	No
Painfully cold fingers	Yes	No
Severe itching	Yes	No

RESPIRATORY

Severe or frequent colds	Yes	No
Constant coughing	Yes	No
Coughing up blood	Yes	No
Recent flu or viral infection	Yes	No
Wheezing or asthma attacks	Yes	No
Difficulty breathing	Yes	No

CARDIOVASCULAR

Chest pain	Yes	No
Shortness of breath	Yes	No
Swelling of your legs	Yes	No

BLOOD

Frequent or easy bruising	Yes	No
Frequent or easy bleeding	Yes	No
Have you ever received and blood transfusion?	Yes	No

GASTROINTESTINAL

Trouble swallowing	Yes	No
Diarrhea	Yes	No
Bloody stools	Yes	No
Stomach ulcers	Yes	No
Jaundice or yellow skin	Yes	No

Bones and Joints

Stiff joints	Yes	No
Painful or swollen joints	Yes	No
Stiff lower back	Yes	No
Back pain while asleep or upon awakening	Yes	No
Muscle aches	Yes	No

Genitourinary

Kidney problems	Yes	No
Bladder trouble	Yes	No
Blood in your urine	Yes	No
Urinary discharge	Yes	No
Genital sores or ulcers	Yes	No
Prostatitis	Yes	No
Testicular pain	Yes	No
Are you pregnant	Yes	No
Do you plan to become pregnant in the near future?	Yes	No