



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

**Have you had any of the following symptoms in the past ONE year?**

**(If Yes, please circle symptom)**

**GENERAL HEALTH:** chills, fevers (persistent or recurrent), night sweats, fatigue, poor appetite, unexplained weight loss.

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

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

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

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

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

**CARDIOVASCULAR:** chest pain, shortness of breath, leg swelling.

**BLOOD:** frequent or easy bruising, frequent or easy bleeding, blood transfusions.

**GASTROINTESTINAL:** trouble swallowing, diarrhea, bloody stools, stomach ulcers, jaundice or yellow skin.

**BONES AND JOINTS:** stiff joints, painful or swollen joints, stiff lower back, back pain while sleeping or awakening, muscle aches.

**GENITOURINARY:** 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

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

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' Heterochromic Iridocyclitis		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.*