

APPENDIX A

Diagnostic Survey for Uveitis

FAMILY HISTORY

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

To your knowledge, has anyone in your family ever had any of the following?

Arthritis or rheumatism	Yes	No
Multiple sclerosis or other autoimmune disease	Yes	No
Sickle cell disease or trait	Yes	No
Uveitis, or inflammation in the eye	Yes	No

SOCIAL HISTORY

Your age (years):

Your current job:

Have you ever traveled outside the United States? Yes No

If yes, where and when?

Have you ever owned a dog or 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

Have you gone hunting or camping? Yes No

Do you smoke cigarettes? Yes No

Have you ever used recreational intravenous drugs? Yes No

Have you ever had sexual relations with a person of the same sex or with a person who engages in same-sex relations? Yes No

PERSONAL MEDICAL HISTORY

Are you allergic to any medications? Yes No

If yes, which medications?

Have you been vaccinated recently? Yes No

If yes, which vaccines?

Please list the medications that you are currently taking, including nonprescription or over-the-counter drugs, nutritional supplements, and herbal or other alternative remedies:

Please list all the eye operations you have had (including laser surgery) and the dates of the procedures:

Please list all the operations you have had (excluding those on the eye) and the dates of the operations:

Have you ever been told by a medical doctor that you have the following conditions?

Anemia (low blood count)	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 (sores in or on the mouth or genitals)	Yes	No
Chickenpox	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
Gonorrhea	Yes	No
Any other sexually transmitted disease	Yes	No
Tuberculosis	Yes	No
Leprosy	Yes	No
Leptospirosis	Yes	No
Lyme disease	Yes	No
Histoplasmosis	Yes	No
<i>Candida</i> infection or moniliasis	Yes	No
Coccidioidomycosis	Yes	No
Sporotrichosis	Yes	No
Toxoplasmosis	Yes	No
Toxocariasis	Yes	No
Cysticercosis	Yes	No
Trichinosis	Yes	No
Whipple disease	Yes	No
HIV infection or 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
Reactive arthritis	Yes	No
Colitis (Crohn disease, ulcerative colitis)	Yes	No
Behçet disease	Yes	No
Sarcoidosis	Yes	No
Ankylosing spondylitis	Yes	No
Erythema nodosa	Yes	No
Temporal arteritis	Yes	No
Multiple sclerosis	Yes	No

Have you had any of the following symptoms or conditions in the past 3 months?

GENERAL HEALTH

Chills	Yes	No
Fever (persistent or recurrent)	Yes	No
Painful or swollen glands	Yes	No
Night sweats	Yes	No
Fatigue (tire easily)	Yes	No
Poor appetite	Yes	No
Unexplained weight loss	Yes	No
Do you feel sick?	Yes	No

HEAD

Headaches	Yes	No
Fainting	Yes	No
Numbness or tingling in your body	Yes	No
Paralysis in parts of your body	Yes	No
Seizures or convulsions	Yes	No

EARS

Hard of hearing or deafness	Yes	No
Ringing or noise 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 nosebleeds	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	Yes	No
Loss of hair	Yes	No
Tick or 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

356 • Uveitis and Ocular Inflammation

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 received blood transfusions?	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
Stiff lower back	Yes	No
Back pain while sleeping or awakening	Yes	No
Muscle aches	Yes	No

GENITOURINARY

Kidney problems	Yes	No
Difficulty with urination	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 future?	Yes	No

Adapted from Foster CS, Vitale AT. *Diagnosis and Treatment of Uveitis*. 2nd ed. Jaypee Brothers Medical Publishers; 2012:123–128.

APPENDIX B

Antimicrobial Agents for Intraocular Injection

Table B-1 Intravitreal Antimicrobial Agents

Agent	Standard Dose	Susceptible Microorganisms	Frequency of Repeated Injections
Antibacterial			
Amikacin	400 µg/0.1 mL	Aerobic GNB (eg, <i>Pseudomonas aeruginosa</i>)	24–48 h
Ceftazidime	2.25 mg/0.1 mL	Aerobic GNB (eg, <i>P aeruginosa</i>); GPB	48–72 h
Clindamycin	1 mg/0.1 mL	GPC (staphylococci, pneumococci); GPB (<i>Bacillus</i> spp); GNB (<i>Bacteroides</i> spp, <i>Fusobacterium</i> spp); <i>Toxoplasma gondii</i>	72 h
Vancomycin	1 mg/0.1 mL	GPC (MRSA and MDR <i>Staphylococcus epidermidis</i>)	72 h
Antifungal			
Amphotericin B	5–10 µg/0.1 mL	Yeasts, filamentous fungi (resistance reported for various species of <i>Aspergillus</i>)	NA
Voriconazole	100 µg/0.1 mL	Broad-spectrum activity against yeasts and molds	NA
Antiviral			
Foscarnet	2.4 mg/0.1 mL	HSV-1, HSV-2, VZV, and CMV	Adjunct to systemic antiviral: 2–3×/wk until retinitis is stable; then weekly if necessary
Ganciclovir	2 mg/0.5 mL or 0.1 mL	CMV > HSV-1, HSV-2, and VZV	Adjunct to systemic antiviral: 2–3×/wk until retinitis is stable; then weekly if necessary

CMV = cytomegalovirus; GNB = gram-negative bacilli; GPB = gram-positive bacilli; GPC = gram-positive cocci; HSV-1 = herpes simplex virus type 1; HSV-2 = herpes simplex virus type 2; MDR = multidrug resistant; MRSA = methicillin-resistant *Staphylococcus aureus*; NA = not applicable; VZV = varicella-zoster virus.

Information from Radhika M, Mithal K, Bawdekar A, et al. Pharmacokinetics of intravitreal antibiotics in endophthalmitis. *J Ophthalmic Inflamm Infect*. 2014 Sep 10;4:22. Also from Sallam AB, Kirkland KA, Barry R, Soliman MK, Ali TK, Lightman S. A review of antimicrobial therapy for infectious uveitis of the posterior segment. *Med Hypothesis Discov Innov Ophthalmol*. 2018;7(4):140–155.

