Today's Date: ____/____/_____

HCQ QUESTIONNAIRE

Name: _____ **Age:** _____ **Weight** (important for medication dosage)**:** _____ **Date of Birth:** ____/____/_____

Race: □ American Indian or Alaska Native □ Native Hawaiian or Other Pacific Islander □ Asian □ Black or African American □ Caucasian

Primary Care Physician: _____ **Last seen:** _____

Referring /Specialty Dr. _____ **Last seen:** _____

Are you currently under the care of an ophthalmologist or optometrist?

□ Yes □ No If yes, please include name and date last seen _____

Have you ever had ocular baseline testing done?

□ Yes □ No □ Unsure

Which medication are you taking that you are being monitored for ocular toxicity?

□ Chloroquine □ Hydroxychloroquine □ Other: _____

Dosage: _____ **Duration:** _____

Why are you taking this medication?

□ Lupus □ Rheumatoid Arthritis. □ Other: _____

Are you currently being treated or monitored for kidney disease?

□ Yes □ No

Any recent major weight loss?

□ Yes □ No

Are you also using the medication Tamoxifen (commonly used to prevent breast cancer)?

□ Yes □ No

Any changes in your vision or color vision?

□ Yes □ No If yes, please explain: _____

Any changes seen with your at home Amsler grid testing?

□ Yes □ No □ Unsure If yes, please attach Amsler with explanation _____

Signature: _____ **Date**: _____

Signature if other than patient: _____ **Date**: _____

Relationship to patient: _____