

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: _____