Form Approved
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Name: ________________________________

North Carolina ID: ______________________

CDC ID: ______________________________

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CDC Study ID: ___________________________________

Charts Reviewed:

Clinic: _________________________ Date of Visit: __ __- __ __- __ __ ☐ Chart Requested ☐ Chart Abstracted

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Clinic: _________________________ Date of Visit: __ __- __ __- __ __ ☐ Chart Requested ☐ Chart Abstracted

Date of syphilis diagnosis (mm/yyyy): __ __ - __ __ - __ __ __ __
Date of ocular syphilis diagnosis (mm/yyyy): __ __ - __ __ - __ __ __ ___

Demographics:

1: Patient’s sex
1: Male 2: Female 3: Transgender 4: Unknown

2: Patient’s age at time of diagnosis: __ __ __ years of age

3: Race/ethnicity:
1: White 2: Black 3: Hispanic or Latino 4: Asian
5: Native Hawaiian/Other Pacific Islander 6: American Indian or Alaska Native

Syphilis Information:

4: Does patient report or have documented history of syphilis prior to this episode?
1: Yes 2: No 3: Unknown

5: If Yes: Approximate date of previous syphilis infection: (mm-yyyy) __ __ - __ __ __ __

6: What stage of syphilis did patient have at time of ocular syphilis diagnosis?
1: Primary syphilis 2: Secondary syphilis 3: Early latent 4: Late latent

7: What was the patient’s syphilis serology result at the time of ocular syphilis diagnosis? Please circle “Yes” for all tests performed and provide test result and date of test

RPR	Yes	No	Result (titer):	Date of test:	mm/dd/yyyy
VDRL	Yes	No	Result (titer):	Date of test: :	mm/dd/yyyy
EIA	Yes	No	Result:	Date of test: :	mm/dd/yyyy
TP-PA	Yes	No	Result:	Date of test: :	mm/dd/yyyy
FTA-ABS	Yes	No	Result:	Date of test:	mm/dd/yyyy
Other-	Type of test:		Result:	Date of test:	mm/dd/yyyy

8: **Did the patient have or report recent history of any symptoms that could be associated with primary or secondary syphilis?**
1: Yes 2: No 3: Unknown

9: If yes, please detail symptoms patient reported: Choose as many as apply:
1: Chancre/genital lesion 2: Skin rash 3: Lymphadenopathy/swollen lymph nodes
4: Alopecia 5: Other: ____

10: Did the patient have a diagnosis of neurosyphilis?
1: Yes 2: No 3: Unknown

11: **Did the patient have any extraocular neurologic symptoms?**
1: Yes 2: No 3: Unknown

12: If yes, please detail neurologic symptoms patient reported: (e.g. headache, neck stiffness):
____

13: Did patient have a lumbar puncture (LP) performed?

1: Yes	2: No	3: Unknown

14: If yes LP was performed please answer the following questions:

1: CSF VDRL result ____________________
2: CSF FTA-abs ____________________
3: CSF WBC ____________________
4: CSF total protein ____________________
5: CSF glucose ____________________

15: What treatment did patient receive and what was the duration?

1: Benzathine penicillin G	Doses _____________________
2: Aqueous crystalline penicillin G IV	Duration (days) ____________
3: Procaine penicillin	Duration (days)_____________
4: Ceftriaxone 2 g daily either IM or IV	Doses _____________________
5: Other _______________________________	

HIV Information:

16: Patient's HIV status:

1: HIV-infected Approximate year of diagnosis (yyyy) __ __ __ __
2: HIV-uninfected Date of most recent negative HIV test if known: (mm-yyyy) __ __ - __ __ __ __
3: Unknown

17: If HIV-uninfected, was the patient on PrEP?

1: Yes	2: No	3: Unknown

Question 6-8: If HIV-infected:

18: Was this a new diagnosis, concurrent with syphilis diagnosis?

1: Yes	2: No	3: Unknown

19: Was patient on cART at time of diagnosis?

1: Yes	2: No	3: Unknown

20: Patient's most recent CD4 count: _____________

21: Patient's most recent viral load: ______________

22: What HIV medication has the patient been on in the last 5 years:

Medication: ______________________________ Dates on medication: ______________________
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23: During the course of this illness, where did the patient seek treatment?

1: STD or HIV Clinic	2: Infectious Disease Clinic	3: Eye Clinic
4: Emergency Room	5: Primary Care Clinic	6: Admitted as inpatient

Sexual Behavior Questions:

24: Gender of the patient’s sexual partners
1: Men only   2: Women only   3: Both men and women   4: Unknown

If patient reports MSM behavior:
25: In the past 12 months, with how many different men has the patient had oral or anal sex?
_____ _____ _____

26: In the past 12 months, with how many different men has the patient had *anal* sex?
_____ _____ _____

27: In the past 12 months, with how many different men has the patient had *oral* sex?
_____ _____ _____

28: How often does the patient say they use condoms?
1: All/most of the time 2: Some of the time   3: Never or almost never

29: In the past 12 months, has the patient exchanged drugs or money for sex?
1: Yes   2: No   3: Unknown

30: Does the patient report using the internet or apps/social media to meet sexual partners?
1: Yes   2: No   3: Unknown

31: (Females only). In the past 12 months, has the patient had sex with a person who is known to her to be an MSM?
1: Yes   2: No   3: Unknown

32: In the past 12 months, has the patient engaged in injection drug use?
1: Yes   2: No   3: Unknown

33: In the past 12 months, has the patient used any of the following injection or non-injection drug?
1: Crack   2: Cocaine   3: Heroin   4: Nitrates/Poppers   5: Methamphetamines
6: Other: ____

34: In the past 12 months has the patient used erectile dysfunction medications?
1: Yes   2: No   3: Unknown

35: In the past 12 months, has the patient been incarcerated?
1: Yes   2: No   3: Unknown

36: In the past 12 months, has the patient been diagnosed with another STD?
1: Yes   2: No   3: Unknown

37: If yes: what was patient diagnosed with:
1: Syphilis   2: Gonorrhea   3: Chlamydia   4: Trichomonas   5: HSV

38: In the past 12 months, has the patient traveled?
1: Yes, but only within the United States   2: Yes, internationally   3: No   4: Unknown

39: If yes to travel, do they report sexual contacts during the travel?
1: Yes   2: No   3: Unknown

Ophthalmologic Exam:

40: **Did the patient have an ophthalmologic exam?**
1: Yes   2: No   3: Unknown

41: Date of first ophthalmologic exam: (mm-dd-yyyy) __ __-__ __-__ __ __ __

42: What were the patient's ocular symptoms?

Choose as many as apply. Please detail, including length of symptoms.

1: Eye pain	Details: ____
2: Red eye	Details: ____
3: Blurry vision/Change in vision	Details: ____
4: Partial vision loss	Details: ____
5: Loss of functional vision in 1 eye	Details: ____
6: Loss of function vision in both eyes	Details: ____
7: Other visual symptoms	Details: ____
8: Unknown	

43: Detail pertinent findings, diagnoses and date of exam:

Choose as many as apply:

1: Scleritis/Keratitis	Details: _________________
2: Uveitis:	Details: _________________
3: Chorioretinitis	Details: _________________
4: Optic Neuritis	Details: _________________
5: Retinal Detachment	Details: _________________
6: Other ocular findings	Details: ____

44: If yes to Uveitis, was it:

1: Anterior Uveitis   2: Posterior Uveitis   3: Panuveitis

45: What was the patient's visual acuity at presentation?

1: Left eye: 20/________

2: Right eye: 20/________

46: Which eye was involved?

1: Left eye only   2: Right eye only   3: Both eyes   4: Unknown

Follow-up Ophthalmologic Exam:

47: Did the patient have a follow up eye exam(s)?

1: Yes   2: No   3: Unknown

48: Date of most recent follow up ophthalmologic exam: (mm-dd-yyyy) __ __-__ __-__ __ __ __

49: What was the patient's visual acuity at most recent follow-up?

1: Left eye: 20/________

2: Right eye: 20/________

50: Did the patient's ocular symptoms improve following treatment?

1: Yes, symptoms completely resolved   2: Yes, but still with residual deficit   3: No