Form Approved

OMB No. 0920-1011

Exp. Date 03/31/2017

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

North Carolina ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDC ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CDC Study ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Charts Reviewed:

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit: \_\_ \_\_- \_\_ \_\_- \_\_ \_\_ □ Chart Requested □ Chart Abstracted

Clinic: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Visit: \_\_ \_\_- \_\_ \_\_- \_\_ \_\_ □ Chart Requested □ Chart Abstracted

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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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates on medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  
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Medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dates on medication: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**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