Form Approved
OMB No. 0920-1385
Exp. Date: 3/31/26

Case report form: Sporotrichosis

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Patient demographic characteristics

Unique patient ID: _____ (site_####)

Site submitting case:

Location of residence for patients (ZIP Code): _____ OR [] Unknown

Age at diagnosis (years): _____

Assigned sex at birth: [] Male [] Female OR [] Unknown

Gender identity: [] Male [] Female [] Transgender, non-binary, or another gender

[] Prefer not to answer/Decline OR [] Unknown

Race and/or ethnicity (select all that apply and enter additional details in the spaces provided):

[] American Indian or Alaska Native

Enter, for example, Navajo Nation, Blackfeet Tribe of the Blackfeet Indian Reservation of Montana, Native Village of Barrow Inupiat Traditional Government, Nome Eskimo Community, Aztec, Maya, etc.

[] Asian – provide details below

[] Chinese [] Asian Indian [] Filipino [] Vietnamese [] Korean [] Japanese

Enter, for example, Pakistani, Hmong, Afghan, etc.

[] Black or African American – provide details below

[] African American [] Jamaican [] Haitian [] Nigerian [] Ethiopian [] Somali

Enter, for example, Trinidadian and Tobagonian, Ghanaian, Congolese, etc.

_____

[] Hispanic or Latino – provide details below

[] Mexican [] Puerto Rican [] Salvadoran [] Cuban [] Dominican [] Guatemalan

Enter, for example, Colombian, Honduran, Spaniard, etc.
_____

[] Middle Eastern or North African – provide details below

[] Lebanese [] Iranian [] Egyptian [] Syrian [] Iraqi [] Israeli

Enter, for example, Moroccan, Yemeni, Kurdish, etc.
_____

[] Native Hawaiian or Pacific Islander – provide details below

[] Native Hawaiian [] Samoan [] Chamorro [] Tongan [] Fijian [] Marshallese

Enter, for example, Chuukese, Palauan, Tahitian, etc.
_____

[] White – provide details below

[] English [] German [] Irish [] Italian [] Polish [] Scottish
Enter, for example, French, Swedish, Norwegian, etc.
_____

Monthly household income (USD) _____

Occupation at time of presumed infection: _____

Industry at time of presumed infection: _____

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Underlying medical conditions (active or present in the 2 years before symptom onset)

Diabetes mellitus [] Yes [] No [] Unknown

Chronic Pulmonary Disease [] Yes [] No [] Unknown

History of smoking [] Yes [] No [] Unknown
If yes (select all that apply): [] Tobacco, current [] Tobacco, previous [] E-nicotine delivery system, current [] E-nicotine delivery system, previous

Documented drug use disorder [] Yes (select all that apply) [] No [] Unknown
[] Alcohol
[] Other drug, specify_____

Chronic kidney disease [] Yes [] No [] Unknown
If yes, on dialysis? [] Yes [] No [] Unknown
If yes, GFR < 60? [] Yes [] No

Liver cirrhosis? [] Yes [] No [] Unknown

Chronic hepatitis without cirrhosis? [] Yes [] No [] Unknown
If yes, [] Hep B [] Hep C

Immunocompromising condition [] Yes [] No [] Unknown
[] HIV infection
[] HIV infection without AIDS (CD4 ≥ 200)
[] HIV infection with AIDS (CD4 < 200) or chart diagnosis of advanced HIV disease
[] Cancer diagnosis, specify _____
[] On chemotherapy, specify _____
Date of cancer diagnosis (mm/dd/yyyy): _____
[] Transplant
[] Solid organ, specify organ _____
[] Hematologic (stem cell)
Date of transplantation (mm/dd/yyyy): _____
[] Immunosuppressive therapy, specify _____
Start date of immunosuppressive treatment (mm/dd/yyyy): _____
[] Other immunocompromised condition, specify _____

Other major underlying condition not listed (specify): _____
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Exposure history

Has patient traveled or lived internationally in their life? [] Yes [] No [] Unknown

- Country 1 _____; Approximate duration of stay (years):
- Country 2 _____; Approximate duration of stay (years):
- Country 3 _____; Approximate duration of stay (years):
- Country 4 _____; Approximate duration of stay (years):
- Country 5 _____; Approximate duration of stay (years):

Did the patient immigrate to the United States? [] Yes [] No [] Unknown
If yes, date of immigration (mm/dd/yyyy): _____ [] Unknown
If yes, country immigrated from: _____ [] Unknown

Any traumatic inoculation ever recalled? [] Yes [] No [] Unknown

If yes, what type of traumatic inoculation? [] Sapronotic [] Zoonotic [] Unknown

If sapronotic, source of infection? [] Sphagnum moss [] Rose bushes [] Hay [] Other, specify ____

If zoonotic, did the animal have a clinical or laboratory diagnosis of sporotrichosis? [] Yes [] No [] Unknown

If zoonotic, what type of animal? [] Cat [] Dog [] Armadillo [] Rat [] Other, specify_____

If yes, please describe geographic location (e.g., city, state): _____

If yes, please describe the material involved (e.g., thorns, branches): _____

If yes, please describe any weather events (e.g., hurricane, flood): _____

If yes, please indicate approximate date of traumatic inoculation (mm/dd/yyyy): _____

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Diagnosis

Did patient have health care facility visits (health center, hospital, etc.) for sporotrichosis symptoms before visit with sporotrichosis diagnosis? [] Yes [] No [] Unknown

If yes, how many visits? _____

Were there misdiagnoses before being diagnosed with sporotrichosis [] Yes [] No [] Unknown

What misdiagnoses, if any, did this patient have before being diagnosed with sporotrichosis (in the last 12 months):

- Please list all misdiagnoses: _____

Laboratory testing (associated with diagnosis):

[] Histopathology [] Not performed [] Unknown if performed
Date (mm/dd/yyyy): _____; Type of stain: _____
Result: _____
[] Cytology [] Not performed [] Unknown if performed
Date (mm/dd/yyyy): _____; Result: _____
[] Fungal culture [] Not performed [] Unknown if performed
Date of collection (mm/dd/yyyy): _____; Positive/Negative: _____
Specimen: _____; Organism(s): _____;

[] Serology [] Not performed [] Unknown if performed
Date of collection (mm/dd/yyyy): _____; Specimen: _____
Positive/Negative: _____ Level: _____;
[] Broad range sequencing [] Not performed [] Unknown if performed
Date of collection (mm/dd/yyyy): _____; Type (e.g., 18s, ITS): _____
Positive/Negative: _____ Organism(s): _____;
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Signs and symptoms noted during patient interview:

Clinical presentation:

[] Fixed cutaneous

[] Lymphocutaneous

[] Multifocal or disseminated cutaneous (≥3 lesions involving 2 different anatomical sites)

[] Extracutaneous

If extracutaneous: [] ocular [] osteoarticular [] pulmonary [] meningitis [] other, specify _____

Signs & Symptoms	Yes/No	Onset Date
Ulcer		
Nodule		
Verrucous lesions		
Plaque-like lesions		
Granulomatous conjunctivitis		
Nodular lymphangitis		
Sporotrichoid spread		
Pain		
Fever		

Night sweats		
Weight loss		
Fatigue		
Dyspnea		
Cough		
Purulent sputum		
Hemoptysis		
Other symptoms, please describe:_____		

Please indicate the specific location(s) on the body of the sporotrichosis lesions (check all that apply):

[] Head or neck

[] Trunk

[] Upper limbs

[] Buttocks, perineum, genitals

[] Lower limbs

Additional comments on anatomical location: _____

Disability	Yes/No	Onset Date	Number of days with disability	Inability to work (Y/N)
Mild motor impairment (has some difficulty in moving around but is able to walk without help)				
Moderate motor impairment (has some difficulty in moving around, and difficulty in lifting and holding objects, dressing and sitting upright, but is able to walk without help				
Severe motor impairment (is unable to move around without help, and is not able to lift or hold objects, get dressed or sit upright)				

Treatment

Was the patient treated for sporotrichosis?

[] Yes [] No [] Unknown [] Missing/Not documented

If yes, list all therapeutic agents (e.g., antifungals, immune response modulators, antibiotics, steroids) in the table below:

Therapeutic Agent Name	Max Daily dose (mg/day)	Route (e.g., IV, PO, IT)	Start Date	Duration of Therapy	Therapy ongoing at time of abstraction	Discontinued due to toxicity. **If yes, describe toxicity**	Therapeutic Drug Monitoring (e.g., serum level of antifungal)
			___ / ___ /	_____days	[] Yes [] No	[] Yes [] No ----------	[] Yes [] No

			________			---------------------	Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value
			____ / ____ / ________	______days	[] Yes [] No	[] Yes [] No --------------------- ---------------------	[] Yes [] No Level 1: Date: Value: Level 2: Date: Value

Notes about treatment:

_____

_____

Did the patient undergo local surgical excision of the sporotrichosis lesions: [] Yes [] No [] Unknown

If yes, date of surgical excision (mm/dd/yyyy): _____

Did the patient receive local hyperthermia for treatment of lesions? [] Yes [] No [] Unknown

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Complications:

Outcome	Yes/No	Onset Date	Notes (e.g., location)
Scarring on skin			
Joint destruction			
Secondary bacterial infection			
Amputation			
Lymphedema			
Other; specify _____			

Did the sporotrichosis infection resolve? [] Yes [] No [] Unknown

If yes, what was the date of clinical resolution (clinical and radiographic cure) (mm/dd/yyyy)::

_____

If no, what was date of last follow-up (mm/dd/yyyy): _____

Did this patient die within 2 years after the sporotrichosis diagnosis? [] Yes [] No [] Unknown

If yes, was sporotrichosis a contributing factor in patient's death? [] Yes [] No [] Unknown

Additional comments:

_____

_____

Appendix 2: Dermatology Life Quality Index Tool

Dermatology Life Quality Index Questionnaire:

1. Over the last week, how itchy, sore, painful, or stinging has your skin problem been?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
2. Over the last week, how embarrassed or self-conscious have you been because of your skin problem?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
3. Over the last week, how much has your skin problem interfered with you going shopping or looking after your home or garden?
    a. Very much
    b. A lot

    c. A little
    d. Not at all
    e. Not relevant
4. Over the last week, how much has your skin problem influenced the clothes you wear?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
5. Over the last week, how much has your skin problem affected any social or leisure activities?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
6. Over the last week, how much has your skin problem made it difficult for your to do any sport?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
7. Over the last week, has your skin problem prevented you from working of studying
    a. Yes
    b. No
    c. Not relevant
        i. If no, over the last week how much has your skin problem been a problem at work or studying?
            1. A lot
            2. A little
            3. Not at all
8. Over the last week, how much has your skin problem created problems with your partner or any of your close friends or relatives?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
9. Over the last week, how much has your skin problem caused any sexual difficulties?
    a. Very much
    b. A lot
    c. A little
    d. Not at all
    e. Not relevant
10. Over the last week, how much of a problem has the treatment for your skin problem been, for example by making your home messy, or by taking up time?
    a. Very much
    b. A lot
    c. A little
    d. Not at all

e. Not relevant