Choroidopathy

Purpose: Record ophthalmologic findings about choroidopathy.

When: At baseline and all followup visits for patients who have ever been diagnosed with choroidopathy. For newly diagnosed patients, at the time of diagnosis of choroidopathy and every followup visit thereafter.

By whom: Study ophthalmologist and clinic coordinator.

A. Clinic, patient and visit identification

1. Clinic ID code: ____ ____ ____ ____

2. Patient ID#: ____ ____ ____ ____

3. Patient name code: ____ ____ ____ ____ ____

4. Date form completed:

____ ____–____ ____ ____–____ ____
day mon year

5. Visit ID code: ____ ____ ____

B. Diagnosis information

6. Date of most recent choroidopathy form completed *(put "N-N-N" at baseline exam or at initial diagnosis of choroidopathy):*

____ ____–____ ____ ____–____ ____
day mon year

7. Newly diagnosed or a baseline visit:

Yes (1) No (2)

13. →

a. Date of diagnosis:

____ ____–____ ____ ____–____ ____
day mon year

b. Eyes affected at time of diagnosis:

	Right	Left
Yes	(1)	(1)
No	(2)	(2)

8. Source of diagnostic information *(check all that apply)*

a. Ophthalmologic exam: (1)

b. Formal visual field testing (eg, Goldmann visual fields): (1)

c. Medical records: (1)

d. Laboratory data: (1)

e. Health care provider: (1)

f. Patient: (1)

g. Other *(specify):* (1)

_____
specify

_____
specify

9. Does/did the patient have sites of infection with *(check all that apply)*

a. Pneumocystis: Yes (1) No (2) Uncertain (3)

Specify site(s)

_____
specify

b. Cryptococcus: Yes (1) No (2) Uncertain (3)

Specify site(s)

_____
specify

c. Tuberculosis: Yes (1) No (2) Uncertain (3)

Specify site(s)

_____
specify

d. MAC: Yes (1) No (2) Uncertain (3)

Specify site(s)

_____
specify

10. Presumed cause of choroidopathy *(check all that apply)*

a. Pneumocystosis: (1)

b. Cryptococcosis: (1)

c. Tuberculosis: (1)

d. MAC: (1)

e. Other *(specify):* (1)

_____
other cause of choroidopathy

f. Don't know: (1)

11. Did the patient receive anti-microbial therapy at least 14 of the 28 days prior to diagnosis:

Yes (1) No (2)

13.

12. Anti-microbial therapy for prophylaxis or treatment received for *(check all that apply)*

a. Pneumocystosis *(specify):* (1)

_____
specify medication

b. Cryptococcosis *(specify):* (1)

_____
specify medication

c. Tuberculosis *(specify):* (1)

_____
specify medication

d. MAC *(specify):* (1)

_____
specify medication

e. Other *(specify):* (1)

_____
specify medication and indication

C. Ophthalmic exam

13. Location of choroidopathy *(check all that apply for each eye)*

	Right	Left
a. Zone 1:	(1)	(1)
b. Zone 2:	(1)	(1)
c. Zone 3:	(1)	(1)
d. Cannot completely assess:	(1)	(1)

Specify which eye(s) and zone(s) cannot be assessed:

_____
specify eye(s) and zone(s)

e. No lesions: (1) (1)

14. Compared to the severity of choroidopathy at the date in item 6 is choroidopathy *(check only one for each eye):*

	Right	Left
Better	(1)	(1)
Same	(2)	(2)
Worse	(3)	(3)
Cannot assess	(M)	(M)
Not applicable	(N)	(N)

15. Is treatment indicated for the choroidopathy *(check only one):*

Yes *(specify which treatment is best, according to best medical judgment)* (1)

_____
specify

No (2)

D. Administrative information

16. Date form reviewed:

____ ____ – ____ ____ ____ – ____ ____
day mon year

17. Study ophthalmologist ID: ____ ____

18. Study ophthalmologist signature:

_____

19. Clinic coordinator ID: ____ ____

20. Clinic coordinator signature:

_____