LSOCA

Eye History

Purpose: Record ophthalmologic history.

When: All clinic visits, baseline and followup. Also at interim visits when an ocular opportunistic infection is diagnosed.

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 of visit:

____ ____–____ ____ ____–____ ____
day month year

5. Visit ID code: ____ ____ ____

6. Sequential number of this EH form: ____ ____

First form completed on any one date is number 01; number additional forms sequentially.

B. Ocular event history

7. Date most recent Eye History form was completed
(record date of enrollment for baseline visit):

____ ____–____ ____ ____–____ ____
day month year

8. Has the patient had retinal detachment surgery since date in item 7, or ever if baseline visit:

a. Right eye
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

b. Left eye:
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

9. Has the patient had cataract surgery since date in item 7, or ever if baseline visit:

a. Right eye
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

b. Left eye:
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

10. Has the patient had ganciclovir implant surgery since date in item 7, or ever if baseline visit:

a. Right eye
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

b. Left eye:
Yes *(record date of surgery):* (1)

____ ____–____ ____ ____–____ ____
day month year

No (2)

11. Has the patient had any other ophthalmologic surgeries or laser procedures since date in item 7, or ever if baseline visit:

	Right	Left
Yes	(1)	(1)
No	(2)	(2)
	15.___	**15.**___

List other surgeries or procedures and in which eye(s).

12. Other surgery or procedure (#1):

a. Name of surgery or procedure and eye(s) involved:

_____

b. Date of surgery or procedure:

____ ____–____ ____ ____–____ ____
day month year

13. Other surgery or procedure (#2):

a. Name of surgery or procedure and eye(s) involved:

_____

b. Date of surgery or procedure:

____ ____–____ ____ ____–____ ____
day month year

14. Other surgery or procedure (#3):

a. Name of surgery or procedure and eye(s) involved:

_____

b. Date of surgery or procedure:

____ ____–____ ____ ____–____ ____
day month year

If additional ophthalmologic surgeries need to be recorded, complete additional forms.

15. Has Stevens-Johnson syndrome occurred since date in item 7, or ever if baseline visit:

Yes (1) No (2)

16. ___

a. Did conjunctival scarring ensue:

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

16. Has Horner's syndrome occurred since date in item 7, or ever if baseline visit:

Yes (1) No (2)

17. Has any of the following occurred since date in item 7, or ever if baseline visit: *(check all that apply)*

	Right	Left
a. CMV retinitis *(If checked, complete a CMV Retinitis form):*	(1)	(1)
b. Herpetic retinitis *(If checked, complete a Herpetic Retinitis form):*	(1)	(1)
c. Toxoplasmic retinitis *(If checked, complete a Toxoplasmic Retinitis form):*	(1)	(1)
d. Cryptococcal choroidopathy *(If checked, complete a Choroidopathy form):*	(1)	(1)
e. Pneumocystis choroidopathy *(If checked, complete a Choroidopathy form):*	(1)	(1)
f. Syphilitic eye disease *(If checked, complete a Syphilitic Eye Disease form):*	(1)	(1)
g. Cranial nerve abnormality *(If checked, complete a Cranial Nerve Abnormality form):*	(1)	(1)
h. Keratitis or conjunctivitis *(If checked, complete a Keratitis/Conjunctivitis form):*	(1)	(1)
i. Non-infectious uveitis *(If checked, complete a Non-Infectious Uveitis form):*	(1)	(1)
j. Optic nerve abnormality *(If checked, complete an Optic Nerve Abnormality form):*	(1)	(1)
k. Ocular motility or alignment abnormality *(If checked, complete a Cranial Nerve Abnormality form):*	(1)	(1)
l. Retinal detachment or re-attachment surgery *(If checked, complete a Retinal Detachment form):*	(1)	(1)
m. Other *(specify):*	(1)	(1)

_____
right eye specify

_____
left eye specify

n. None of the above:	(1)	(1)

18. Has the patient had any of the following abnormalities diagnosed since date in item 7, or ever if baseline visit:
(check all that apply for each eye)

	Right	Left
a. Vitreous hemorrhage:	(1)	(1)
b. Endophthalmitis:	(1)	(1)
c. Chronic ocular hypotony *(other than perioperatively):*	(1)	(1)
d. Herpes zoster ophthalmicus:	(1)	(1)
e. Pupil abnormality:	(1)	(1)

_____
specify pupil abnormality

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

_____
right eye specify

_____
left eye specify

g. None of the above:	(1)	(1)

C. Administrative information

19. Date form reviewed:

____ ____–____ ____ ____–____ ____
day month year

20. Study Ophthalmologist ID: ____ ____

21. Study Ophthalmologist signature:

_____

22. Clinic coordinator ID: ____ ____

23. Clinic coordinator signature:

_____