Syphilitic Eye Disease

Purpose: Record ophthalmologic and laboratory findings about syphilitic eye disease.
When: At clinic followup visits when syphilitic eye disease is diagnosed or a confirmed, or prior occurrence is first reported.
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: ____ ____ ____

B. Syphilitic eye disease

6. Syphilitic eye disease diagnosis

a. Date of diagnosis: ____ ____–____ ____ ____–____ ____ (day, month, year)

b. Eyes affected at time of diagnosis:

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

7. 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

8. Type of syphilitic eye disease *(check all that apply)*

	Right	Left
a. Syphilitic iridocyclitis:	(1)	(1)
b. Syphilitic chorioretinitis:	(1)	(1)
c. Syphilitic papillitis:	(1)	(1)
d. Other *(specify)*:	(1)	(1)

____
right eye specify

____
left eye specify

	Right	Left
e. Don't know:	(1)	(1)
f. Not applicable:	(N)	(N)

C. Diagnostic criteria for syphilis

9. Specific serologic test performed:

Yes	(1)
No	(2) → **11.**
Don't know	(9) → **11.**

10. Type of specific serologic test:

a. FTA-ABS:

Positive	(1)
Negative	(2)
Not done	(3)

b. MHA-TP:

Positive	(1)
Negative	(2)
Not done	(3)

c. HATTS:

Positive	(1)
Negative	(2)
Not done	(3)

11. Non-specific serologic test performed:

- Yes (1)
- No (2) → 13.
- Don't know (9) → 13.

12. Non-specific serologic test:

a. RPR:

- Positive (1)
  - Titer ____ : ____ ____ ____ ____
- Negative (2)
- Not done (3)

b. VDRL:

- Positive (1)
  - Titer ____ : ____ ____ ____ ____
- Negative (2)
- Not done (3)

C. Administrative information

13. Date form reviewed:

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

14. Ophthalmologist ID: ____ ____

15. Ophthalmologist signature:

____

16. Clinic coordinator ID: ____ ____

17. Clinic coordinator signature:

____