

C. Ophthalmic exam

13. Number of relapses since date in item 6
*(For baseline, # of relapses since first diagnosis.
 For followup, # of relapses since last study visit.
 Record "N" if newly diagnosed):*

14. Location of toxoplasmic retinitis lesion(s)
(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)

15. Number of visible discrete toxoplasmic lesions
(Discrete lesions are 750 μ or more in diameter and 750 μ or more from another lesion. Record "N" if no lesion, "M" if cannot assess)

a. Right eye: _____

b. Left eye: _____

16. Estimate area of retina with toxoplasmic retinitis
(record "N" if no lesion, "M" if cannot assess)

a. % of retina with toxoplasmic retinitis
 OD (right eye) *(estimate to nearest 5 percent):*

_____ %

b. % of retina with toxoplasmic retinitis
 OS (left eye) *(estimate to nearest 5 percent):*

_____ %

17. Active lesion *(check only one for each eye):*

	Right	Left
Yes	(1)	(1)
No	(2)	(2)
Cannot determine	(M)	(M)
No lesions	(N)	(N)

18. Lesion activity since date in item 6 for pre-existing lesion(s)
(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)

19. New lesion(s) since date in item 6
(check only one for each eye):

	Right	Left
Yes	(1)	(1)
No	(2)	(2)
Cannot assess	(M)	(M)
Not applicable <i>(for BL or initial diagnosis only)</i>	(N)	(N)

22. _____ **22.** _____

20. Number of new lesions
(record "N" if eye has no new lesions, "M" if cannot assess)

a. Right eye: _____

b. Left eye: _____

21. Location of new lesion(s)
(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 new lesions: (1) (1)

D. Administrative information

22. Date form reviewed:

____ - ____ - ____
day mon year

23. Ophthalmologist ID: _____

24. Ophthalmologist signature:

25. Clinic coordinator ID: _____

26. Clinic coordinator signature:
