

CDC/Chicago Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number _____

If you have a suspected LGV case, please fax report to Chicago Department of Public Health (CDPH), STI Surveillance Unit at (312) 745-7627.

Reporting of Case

	Name of Person Completing this Form	Phone
/ / Today's Date	Affiliation (e.g., clinic, health department)	Fax
	E-mail Address	

Patient's Address at Time of Visit for Suspected LGV

Last Name	First Name	Middle Initial	Home Phone
Residence Street (Apt No.)		Work Phone	
City	State	Zip	Health Jurisdiction/County/State/Country of Residence

Patient's Demographic Information

<p>Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender (<input type="checkbox"/> M-to-F <input type="checkbox"/> F-to-M)</p> <p>Date of Birth: / /</p> <p>Age: <input style="width: 40px;" type="text"/></p>	<p>Hispanic/Latino? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U</p> <p>Race (check all that apply):</p> <p><input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native</p> <p><input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander</p> <p><input type="checkbox"/> Asian <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Unknown</p>
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Clinical Information

<p>Date of Initial Health Care Visit for Suspected LGV: / /</p> <p>Clinic where patient was seen for suspected LGV:</p> <p style="border-bottom: 1px solid black;">Clinic Name</p> <p style="border-bottom: 1px solid black;">Street</p> <p style="border-bottom: 1px solid black;">City</p> <p style="border-bottom: 1px solid black;">State</p> <p style="border-bottom: 1px solid black;">Zip</p> <p>Patient's Clinic ID#: _____</p>	<p>Clinic Type:</p> <p><input type="checkbox"/> STD Clinic <input type="checkbox"/> ID Clinic</p> <p><input type="checkbox"/> HIV/AIDS Clinic <input type="checkbox"/> GI Clinic</p> <p><input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Emergency Department</p> <p>Setting:</p> <p><input type="checkbox"/> Kaiser <input type="checkbox"/> Public Community Clinic</p> <p><input type="checkbox"/> Private Practice <input type="checkbox"/> Correctional</p> <p><input type="checkbox"/> University Hospital <input type="checkbox"/> Other: _____</p> <p><input type="checkbox"/> Emergency Department</p>
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What was the patient's chief complaint(s) at the initial clinic visit for suspected LGV?
(Please list): _____

Is this patient the sex partner of a person diagnosed with proven or suspected LGV? Y N U

Does the patient report having a sex partner with symptoms consistent with LGV? Y N U

This form adapted from the California Department of Health Services, STD Control Branch.

/ /	DIS	Sup
Date Case Closed		

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Symptoms

At the initial clinic visit for suspected LGV, did the patient give a history of having any symptoms? Y N U

If "Yes", Symptom(s):	Approximate Date of Onset	Still Present at Exam?	If NO, Duration (# Days)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Anal Discharge	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Rectal Bleeding	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Anal Spasms (cramping)	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Urgency with pain with bowel movement (Tenesmus)	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Constipation	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Lymph node enlargement in groin	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Ulcer Painful? <input type="checkbox"/> Y <input type="checkbox"/> N Site: _____	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Papule Painful? <input type="checkbox"/> Y <input type="checkbox"/> N Site: _____	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Fever	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Weight Loss	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Malaise	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Other (<i>specify</i>): _____	/ /	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	_____

Physical Exam Findings

- Y N U Inguinal Lymphadenopathy (*if Yes, complete below*)
- Y N U Unilateral
 - Y N U Bilateral
 - Y N U Tender at Adenopathy site
 - Y N U Bubo
If Yes, is it draining? Y N U
- Y N U Ulcer (*if Yes, complete below*)
- Tender? Y N Site: _____
- Y N U Papule (*if Yes, complete below*)
- Tender? Y N Site: _____

- Y N U Mucous or purulent anal discharge
- Y N U Rectal bleeding
- Y N U Fever
- Y N U Weight Loss
- Y N U Other (*specify*): _____
- _____
- _____
- _____

Clinical Procedures

	Indicate Findings	If Yes to Anoscopy, Proctoscopy or Sigmoidoscopy, biopsy done?
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Rectal exam (digital) done?	_____	
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Anoscopy done?	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Proctoscopy done?	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Sigmoidoscopy done?	_____	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U

Chlamydia History

Did the patient **ever** have a history of chlamydia infection (*not including the current diagnosis*)? Y N U If Yes, # Infections _____

Did the patient have a history of chlamydia infection in the **past year** (*not including the current diagnosis*)? Y N U _____

If Yes, Anatomic Site(s) of Last Infection:

<input type="checkbox"/> Urine	<input type="checkbox"/> Pharyngeal	Date: ____ / ____ / ____ Treatment: _____
<input type="checkbox"/> Urethral/Cervical	<input type="checkbox"/> Other: _____	
<input type="checkbox"/> Rectal	<input type="checkbox"/> Unknown	

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Patient's Self-Reported HIV Status

Patient knows HIV status? Y N U R

If Yes, Status? Infected Not Infected Refused

If Infected, Date of Diagnosis (mm/yyyy) _____ / _____ / _____

If Not Infected, Date of Last Test (mm/yyyy) _____ / _____ / _____

Taken anti-retroviral therapy: Ever? Y N U

Last 12 Months? Y N U

Currently? Y N U

Chlamydia Tests Conducted

Check which chlamydia tests were conducted at visit for suspected LGV and test results, if available:

CT Specimen Type & Lab Used	CT Test Results	Test Type (if known)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Urine Lab Name: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> GenProbe Aptima <input type="checkbox"/> Roche Amplicor <input type="checkbox"/> Unknown <input type="checkbox"/> BD ProbeTec <input type="checkbox"/> Other: _____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Urethral Swab Lab Name: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> GenProbe Aptima <input type="checkbox"/> Other: _____ <input type="checkbox"/> GenProbe PACE 2 <input type="checkbox"/> BD ProbeTec <input type="checkbox"/> Unknown <input type="checkbox"/> Roche Amplicor <input type="checkbox"/> Antigen detection (specify): _____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Rectal Swab If Yes: <input type="checkbox"/> Blind Specimen <input type="checkbox"/> Directed under Anoscopy/Proctoscopy/Sigmoidoscopy <input type="checkbox"/> Unknown Lab Name: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> GenProbe Aptima <input type="checkbox"/> Other: _____ <input type="checkbox"/> Roche Amplicor <input type="checkbox"/> BD ProbeTec <input type="checkbox"/> Unknown <input type="checkbox"/> Antigen detection (specify): _____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Oropharyngeal Swab Lab Name: _____	<input type="checkbox"/> Positive <input type="checkbox"/> Equivocal <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> GenProbe Aptima <input type="checkbox"/> Other: _____ <input type="checkbox"/> Roche Amplicor <input type="checkbox"/> BD ProbeTec <input type="checkbox"/> Unknown <input type="checkbox"/> Antigen detection (specify): _____
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Serology Lab Name: _____	Titer: _____ Optical Density: _____	<input type="checkbox"/> CF <input type="checkbox"/> MIF <input type="checkbox"/> IFA <input type="checkbox"/> EIA <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Other: _____ Lab Name: _____	Describe Results: _____	Describe Test Type: _____

Other STD Tests Conducted

Check other STDs for which tests were conducted at the initial LGV clinic visit and test results, if available:

STD	Test Results	Test Type (if known)
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Gonorrhea - Urine	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> NAATs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Gonorrhea - Rectal	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> NAATs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Gonorrhea - Oropharyngeal	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> NAATs <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Trichomonas	<input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	<input type="checkbox"/> Culture <input type="checkbox"/> Wet mount <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Syphilis - Non-Treponemal	<input type="checkbox"/> Reactive - Titer: 1: _____ <input type="checkbox"/> Non-reactive <input type="checkbox"/> Unk	Serology: <input type="checkbox"/> RPR <input type="checkbox"/> VDRL <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Syphilis - Treponemal	<input type="checkbox"/> Reactive <input type="checkbox"/> Non-reactive <input type="checkbox"/> Unk	Serology: <input type="checkbox"/> FTA-abs <input type="checkbox"/> TP-PA <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Syphilis Ulcer/Chancre	Site #1: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk Site #2: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	#1: <input type="checkbox"/> Darkfield <input type="checkbox"/> DFA-TP <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk #2: <input type="checkbox"/> Darkfield <input type="checkbox"/> DFA-TP <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Genital/Rectal Herpes	Site #1: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk Site #2: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Unk	#1: <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk #2: <input type="checkbox"/> Culture <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unk
<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Other: _____	<input type="checkbox"/>	<input type="checkbox"/>

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LGV Treatment

Was treatment given for suspected LGV? Y N U

If Yes, Drug: _____ Dose: _____ Frequency: _____ # Days: _____

Patient's Sexual History

Number of **male sex partners** the patient had in the past **12 months**: _____

Number of **male sex partners** the patient had in the past **3 months**: _____ Of these, # **New**: _____ # **Anonymous**: _____

In the past **3 months**:

Did the patient have sex (anal, vaginal) without a condom with any of these male partners? Y N U

Did the patient have receptive anal intercourse with any of these male partners? Y N U

Did the patient have receptive anal fisting with any of these male partners? Y N U

For male patients only: Did the patient have insertive anal intercourse with any of these male partners? Y N U

Number of **female sex partners** the patient had in the past **12 months**: _____

Number of **female sex partners** the patient had in the past **3 months**: _____ Of these, # **New**: _____ # **Anonymous**: _____

For male patients only:

In the past **3 months**:

Did the patient have sex (anal, vaginal) without a condom with any of these female partners? Y N U

Did the patient have insertive anal intercourse with any of these female partners? Y N U

Risk Factors

Which of the following drugs were used in the past **12 months**?

Marijuana Y N U R Other #1: Y N U R

Crack Cocaine Y N U R Specify: _____

Cocaine Y N U R Other #2: Y N U R

Ecstasy Y N U R Specify: _____

Heroin Y N U R Other #3: Y N U R

Methamphetamine Y N U R Specify: _____

In the **12 months** before the suspected LGV diagnosis:

Been in Jail/Juvenile Detention Center? Y N U R

Been in Prison/Long-Term Correctional Facility? Y N U R

Been a Member of Gang? Y N U R
Gang Name _____

Gave Money/Drugs for Sex? Y N U R

Received Money/Drugs for Sex? Y N U R

Had any Sex Partners who have ever been in jail/prison/juvenile hall? Y N U R

Venues

In the **3 months** before this suspected LGV diagnosis, where did the patient meet any **NEW** or **ANONYMOUS** sex partners? R

No new or anonymous partners in past 3 months

	Meeting Venue	Name(s) of Venues	Meeting Venue	Name(s) of Venues
Bars/Clubs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	_____	Circuit Parties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R _____
Baths/Spas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	_____	Telephone Chat Lines	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R _____
Sex Clubs	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	_____	Other #1	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R _____
Internet/Chat Rooms/Email	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	_____	Other #2	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R _____
Private Parties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	_____	Other #3	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R _____

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Patient's Travel History

Did the patient travel to Europe in the past **3 months**? Y N U

If Yes, please indicate location, dates, and if the patient had sex there (other than someone with whom they traveled to that location)?

Sex There?

Location: _____ Dates: _____ Y N U

Location: _____ Dates: _____ Y N U

Location: _____ Dates: _____ Y N U

Did the patient travel anywhere else in the past **3 months**? Y N U

If Yes, please indicate location, dates, and if the patient had sex there (other than someone with whom they traveled to that location)?

Sex There?

Location: _____ Dates: _____ Y N U

Location: _____ Dates: _____ Y N U

Location: _____ Dates: _____ Y N U

Additional Comments

Additional comments you may have (e.g., other history, risk factors, or behaviors of relevance for this suspected case):