

# CDC/California Lymphogranuloma Venereum (LGV) Suspected Case Report Form

Case Number \_\_\_\_\_

**Please report any suspected or confirmed LGV case to your local STD Control office. The public health staff from that office will complete this case report form and fax a copy to Denise Gilson at (916) 552-8974. For clinical questions, please call your local STD Control office or contact Dr. Chris Hall at (510) 625-6006 or [chall@dhs.ca.gov](mailto:chall@dhs.ca.gov).**

## Reporting of Case

/ / Today's Date	Name of Person Completing this Form	Phone
	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

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 )	Hispanic/Latino? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U  Race (check all that apply): <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Black <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unknown	Emergency Contact Name _____ Emergency Contact Relationship _____ Emergency Contact Phone _____
Date of Birth: / / Age: <input style="width: 40px;" type="text"/>		

## Clinical Information

Date of Initial Health Care Visit for Suspected LGV: / /  Clinic where patient was seen for suspected LGV:  Clinic Name _____ Street _____ City _____ State _____ Zip _____  Patient's Clinic ID#: _____	Clinic Type: <input type="checkbox"/> STD Clinic <input type="checkbox"/> ID Clinic <input type="checkbox"/> HIV/AIDS Clinic <input type="checkbox"/> GI Clinic <input type="checkbox"/> Primary Care <input type="checkbox"/> Other: _____ <input type="checkbox"/> Emergency Department  Setting: <input type="checkbox"/> Kaiser <input type="checkbox"/> Public Community Clinic <input type="checkbox"/> Private Practice <input type="checkbox"/> Correctional <input type="checkbox"/> University Hospital <input type="checkbox"/> Other: _____ <input type="checkbox"/> Emergency Department
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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

/ /	DIS	Sup
<b>Date Case Closed</b>		

### 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 (specify): _____	/ /	<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 Tenderness
  - 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 Digital rectal exam 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:  Urine  Urethral/Cervical  Rectal  Pharyngeal  Other: \_\_\_\_\_  Unknown

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Treatment: \_\_\_\_\_

### 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 <input type="checkbox"/> Blind Specimen If Yes: <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"/> 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 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: _____ Site #2: _____	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: _____ Site #2: _____	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"/>

### LGV Treatment

Was treatment given for suspected LGV?  Y  N  U      If Yes, Treatment Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

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 **2 months**: \_\_\_\_\_ Of these, # **New**: \_\_\_\_\_ # **Anonymous**: \_\_\_\_\_

In the past **2 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

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

Number of **female sex partners** the patient had in the past **2 months**: \_\_\_\_\_ Of these, # **New**: \_\_\_\_\_ # **Anonymous**: \_\_\_\_\_

**For male patients only:**

In the past **2 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 **2 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 2 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	_____

### Patient's Travel History

Did the patient travel to Europe in the past **2 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 **2 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):