PHILIPPINE NATIONAL REGISTRY FOR EMB-RELATED TOXIC OPTIC NEUROPATHY

A. GENERAL INFORMATION

1. EyeMD/ REPORTER Information				2. PATIENT Information					
1a. Name				2a. Name				2b. Age	
1b. Clinic Address				2c. Gender		2d. Ht		2e. Wt	
				2f. City of Residence					
1c. Tel #		1d. Mobile #		2g. Contact #					
1e. Email				3. Date of Initial Consult (mm/dd/yy)					

B. HISTORY/SYMPTOMATOLOGY/DRUG INFO

4. Past Ocular Hx (List all previous Dx, if any)	4a.OD		4b.OS	
5. Systemic Disease (*special note*: inquire about kidney disease/status)				
6. Concomitant Drug Intake (other than anti-TB)				

7. ***Anti-TB REGIMEN 1***: Brand Name (optional) ______________________________ ; OR SPECIFY:

Component		Daily Dose in mg.		Start of Tx (mm/dd/yy)		End of Tx (mm/dd/yy)
Ethambutol (EMB)						
Isoniazid (INH)						
Rifampicin (RIF)						
Pyrazinamide (PZA)						
Px Compliance (check one)	GOOD		FAIR		POOR	

8. ***Anti-TB REGIMEN 1***: Brand Name (optional) ______________________________ ; OR SPECIFY:

Component		Daily Dose in mg.		Start of Tx (mm/dd/yy)		End of Tx (mm/dd/yy)
Ethambutol (EMB)						
Isoniazid (INH)						
Rifampicin (RIF)						
Pyrazinamide (PZA)						
Px Compliance (check one)	GOOD		FAIR		POOR	

9. Prescribing Individual's Medical Field/Specialty						
10. Was the patient warned about potential adverse ocular effects of anti-TB drugs? (check one)	YES		NO			
11. How soon after intake of anti-TB meds did visual symptoms occur? (in weeks)						
12. Visual symptoms first noted in: (check one)	OD		OS		OU	
13. FIRST visual parameter affected (check one)	Visual Acuity		COLOR		Others (specify)	

C. EYE EXAMINATION

	OD	OS
14. Best Corrected Distance Visual Acuity on 1st Consult		
15. Visual Field Defect (central, ceco-central , generalized, bitemporal, etc)		
16. Color Vision (Ishihara Color Plates)	____ out of ____	____ out of ____
17. Other Color Tests (please specify ______________________)		
18. Fundus Appearance (normal, optic disc pallor, cupping, retinopathy, etc)		
19. Concomitant Eye Disease/Diagnosis (cataract, glaucoma, etc.)		
20. Relative Afferent Pupillary Defect (RAPD)—leave blank if none		

Thank you for your contribution! Please submit the completed form by:

Fax: 02-638-5837

Mail: American Eye Center, Level 5, Shangri-La Plaza Mall, EDSA cor Shaw Blvd, Ortigas Center, Mandaluyong City, Philippines 1554

Email: rich_kho@yahoo.com (rescan filled-out form)