

EUROPEAN REGISTRY OF SEVERE CUTANEOUS ADVERSE REACTIONS TO DRUGS AND COLLECTION OF BIOLOGICAL SAMPLES

R e g i S C A R

Case Record Form

Interview no.

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HSS/DRESS

☐

This is a confidential document of high importance for health research. In case of loss, if someone finds it,
please send it to the following address:

Dokumentationszentrum schwerer Hautreaktionen (dZh)
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GERMANY

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EUROPEAN REGISTRY OF SEVERE CUTANEOUS ADVERSE REACTIONS TO DRUGS AND COLLECTION OF BIOLOGICAL SAMPLES

R e g i S C A R

Interview no.

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PATIENT'S DATA

Initials of the patient

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date of birth

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Age

--	--	--

country of birth

Gender

☐

male

☐

female

Death before interview

☐

no

☐

yes

Participation
agreed to by the patient

☐

registry

☐

cohort study

☐

genetic study

Interview no.

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HOSPITAL DATA

Reporting hospital / department

hospital no.

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date of admission

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Treating hospital / department

hospital no.

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date of admission

--	--	--	--	--	--

Date of notification

--	--	--	--	--	--

date of interview

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Transfer from one or more hospitals to the reporting / treating hospital:

☐

no

☐

yes

☐

unknown

If yes, first hospital:

hospital no.

--	--	--	--

date of admission

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Retrospective assessment

☐

no

☐

yes

Development of skin reaction

☐

prior to admission

☐

during inhospital stay

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DIAGNOSES AND CLINICAL COURSE

Admission diagnoses

1) _____

2) _____

3) _____

Date

Clinical symptoms

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Fever

no

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yes

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unknown

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If yes,

date of onset

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date of normalization*

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highest temperature (°C)

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* if cured before admission

Interview no.

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FOR CASES OF HSS / DRESS ONLY

SKIN SYMPTOMS

	no	yes	unknown	date of onset	date of normalization
Burning, pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Pruritus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
Exanthema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>

If yes,

- maculopapular / morbilliform

☐

- urticarial

☐

- confluent erythema

☐

- exfoliative dermatitis

☐

- other: _____
(please specify)

☐

	no	yes	unknown
Specific lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

	no	yes	unknown	date of onset	date of normalization
- edematous erythema		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
- target-like lesions		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
- pustules		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
- purpura		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
- infiltrated plaques		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>
- eczema-like lesions		<input type="checkbox"/>		<input type="text"/>	<input type="text"/>

	no	yes	unknown	date of onset
Blisters / erosions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
Nikolski's sign	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

	no	yes	unknown	date of maximum	information from investigator/photos	chart
Maximum of erythema (percentage related to the BSA)		<input type="text"/>		<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>

	no	yes	unknown	date of maximum
Maximum of detachment (percentage related to the BSA) (if blisters/erosions were seen)		<input type="text"/>		<input type="text"/>

	no	yes	unknown	date of resolution
Resolution of erythema/ specific lesions \geq 15 days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

	no	yes	unknown	date of onset
Facial edema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

Interview no.

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FOR CASES OF HSS / DRESS ONLY

MUCOSAL SYMPTOMS no yes unknown
☐ ☐ ☐

If yes, please specify:

date of onset

--	--	--	--	--	--

date of normalization

--	--	--	--	--	--

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FOR CASES OF HSS / DRESS ONLY

ORGAN INVOLVEMENT 1

LIVER

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

date of diagnosis

--	--	--	--	--	--

- Jaundice

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

date of onset

--	--	--	--	--	--

Is there a suspicion of excessive alcohol intake?

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

chronic	<input type="checkbox"/>	acute	<input type="checkbox"/>
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KIDNEY

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

date of diagnosis

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LUNG

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

date of diagnosis

--	--	--	--	--	--

DYSPNEA

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

date of onset

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FOR CASES OF HSS / DRESS ONLY

ORGAN INVOLVEMENT 2

	no	yes	unknown
HEART / MUSCLES	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

date of diagnosis

--	--	--	--	--	--

date of onset

--	--	--	--	--	--

- Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Muscular pain or weakness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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GI-TRACT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, please specify:

date of diagnosis

--	--	--	--	--	--

date of onset

--	--	--	--	--	--

- Abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Dysphagia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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PALPABLE LYMPH NODES (>1cm, at least two sites)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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date of diagnosis

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NEUROLOGICAL SYSTEM

date of onset

- Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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- Paresis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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SORE THROAT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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date of onset

--	--	--	--	--	--

OTHER ORGAN INVOLVEMENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If yes, please specify:

date of diagnosis

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If yes, please specify:

date of diagnosis

--	--	--	--	--	--

FOR CASES OF HSS / DRESS ONLY

MEDICAL IMAGING AND BIOPSIES 1

Have the following investigations been done?

- X-ray chest	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	
- Chest-CT	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	
- Bronchial endoscopy	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	
- ECG	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	
- Echocardiogram	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	
- Abdominal sonography	no <input type="checkbox"/>	yes <input type="checkbox"/>	unknown <input type="checkbox"/>	date of performance <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
If yes,	normal <input type="checkbox"/>	abnormal <input type="checkbox"/>	_____	
			please specify	

FOR CASES OF HSS / DRESS ONLY

MEDICAL IMAGING AND BIOPSIES 2

Have the following investigations been done?

- Gastrointest. endoscopy no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

- Other imaging (CT/MRI) no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

If yes, normal ☐ abnormal ☐ _____
please specify

- Liver biopsy no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

- Kidney biopsy no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

- Biopsy of other organ no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

- Puncture of other organ no ☐ yes ☐ unknown ☐ date of performance

If yes, normal ☐ abnormal ☐ _____
please specify

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FOR CASES OF HSS / DRESS ONLY

BLOOD CELL COUNT

Date of sampling:

--	--	--	--	--	--

Laboratory number:

--	--

(ascending number for each lab, only if first entry or the lab changed, lower and upper limits must be entered)

	Value (numerical)	Lower limit (numerical)	Upper limit (numerical)	Unit (text)
Leucocytes				
Neutrophils				
Eosinophils				
Basophils				
Lymphocytes				
Atyp. lymphocytes				
Monocytes				
Platelets				
HB				
Quick				
PTT				
Other 1.:				
Other 2.:				
Other 3.:				
Other 4.:				
Other 5.:				

After saving the data you will be asked, whether you want to complete a further e-form.

FOR CASES OF HSS / DRESS ONLY

CLINICAL CHEMISTRY

Date of sampling:

Laboratory number:

(ascending number for each lab, only if first entry or the lab changed, lower and upper limits must be entered)

	Value (numerical)	Lower limit (numerical)	Upper limit (numerical)	Unit (text)
ALAT				
ASAT				
GGT				
AP				
LDH				
Bilirubin				
Lipase				
Amylase				
Creatinine				
Creatinine clearance				
Urea				
Proteinuria				
Hematuria				
Leucocyturia				
CK				
CK-MB				
Troponin				
CRP				
PH				
PO ₂				
PCO ₂				
HCO ₃				
SaO ₂				
Base excess				
Other 1.:				
Other 2.:				
Other 3.:				
Other 4.:				
Other 5.:				

After saving the data you will be asked, whether you want to complete a further e-form.

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FOR CASES OF HSS / DRESS ONLY

LABORATORY VALUES 1

Have the following laboratory examinations been done?

		n	y	u	If yes, please specify:	
					Date of sampling	Comments (result, method, titer, etc.)
Blood culture	1					
	2					

		n	y	u	If yes, please specify:		
					Date of Sampling	Suggesting recent infection	Comments (result, method, titer, etc.)
Chlamydia	1						
	2						
Mycoplasma	1						
	2						

Other laboratory examinations

	If yes, please specify:		
	Date of Sampling	Suggesting recent infection	Comments (result, method, titer, etc.)
Other 1.:			
Other 2.:			
Other 3.:			
Other 4.:			
Other 5.:			

FOR CASES OF HSS / DRESS ONLY

LABORATORY VALUES 2

Have the following laboratory examinations been done?

		n	y	u	If yes, please specify:		
					Date of Sampling	Suggesting recent infection	Comments (result, method, titer, etc.)
HAV	1						
	2						
HBV	1						
	2						
HCV	1						
	2						
EBV	1						
	2						
CMV	1						
	2						
HHV6	1						
	2						
Parvovirus B19	1						
	2						
ANA							
Other laboratory examinations							
					If yes, please specify:		
					Date of Sampling	Suggesting recent infection	Comments (result, method, titer, etc.)
Other 1.:							
Other 2.:							
Other 3.:							
Other 4.:							
Other 5.:							

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FOR ALL CASES

FURTHER INFORMATION FOR CASE VALIDATION

	no	yes	unknown	date of first occurrence						
Photographs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Biopsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						
Diagnosis by a dermatologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<table border="1"><tr><td></td><td></td><td></td><td></td><td></td><td></td></tr></table>						

If yes, please specify: _____

Further photographs:

Date	Notes
_____	_____
_____	_____
_____	_____

SCORTEN-PARAMETERS (within 3 days after admission)

	no	yes	not done
- Urea > 10 mmol/l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, highest value: _____ mmol/l			
- Glycemia > 14 mmol/l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, highest value: _____ mmol/l			
- Bicarbonate < 20 mmol/l	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If yes, lowest value: _____ mmol/l			
- Heart rate > 120 /min	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Interview no.

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SYMPTOMS / EVENTS WITHIN 1 MONTH BEFORE THE RECENT SKIN REACTION

	no	yes	unknown	date of onset	date of normalization*
Herpes labialis or fever blisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Do you have recurrent herpes labialis or fever blisters?

no	yes	unknown	date of last eruption
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

	no	yes	unknown	date of onset	date of normalization*
Herpes genitalis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Do you have recurrent genital herpes?

no	yes	unknown	date of last eruption
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

*if cured before admission

Interview no.

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SYMPTOMS / EVENTS WITHIN 1 MONTH BEFORE THE RECENT SKIN REACTION

	no	yes	unknown
Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

		date of onset	date of normalization*
- influenza / influenza-like illness	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- rhinopharyngitis / common cold	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- tonsillitis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- sinusitis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- acute otitis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- acute bronchitis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- pneumonia	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- acute gastroenteritis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
- acute cystitis	<input type="checkbox"/>	<input type="text"/>	<input type="text"/>
* bacterial infection proven	<input type="checkbox"/>		
* prior cystitis	<input type="checkbox"/>		
- other infections	<input type="checkbox"/>		

	date of onset	date of normalization*
_____ (please specify)	<input type="text"/>	<input type="text"/>
_____ (please specify)	<input type="text"/>	<input type="text"/>

HIV-status

	no	yes	unknown
HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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If yes,
most recent CD4 count per µl:

*if cured before admission

Interview no.

HAVE YOU IN THE PAST HAD ANY OF THE FOLLOWING DISEASES?

	no	yes	unknown	year of event
- Atopic dermatitis / childhood eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- SCAR	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes, please specify: _____

	no	yes	unknown
Severe liver disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

(please specify)

	no	yes	unknown
Severe kidney disorders?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

(please specify)

	no	yes	unknown
Rheumatic / autoimmune diseases?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

- rheumatoid arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- systemic lupus erythematosus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>
- other:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/>

If yes,

(please specify)

Interview no.

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Other diseases

	no	yes	unknown	year of event
- Diabetes mellitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
- Convulsive disorder / epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
- Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
- Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
- Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/>
* Colitis ulcerosa		<input type="checkbox"/>		<input type="text"/> <input type="text"/>
* Crohn's disease		<input type="checkbox"/>		<input type="text"/> <input type="text"/>
- Malignant diseases / cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

If yes, please specify: _____

If yes, please specify: _____

Radiotherapy

	no	yes	unknown	date of most recent therapy
Have you ever had x-ray or radiotherapy? (not UV-radiation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

If yes, for what indication?

- lymphoma	<input type="checkbox"/>	_____
		(please specify)
- brain tumor	<input type="checkbox"/>	_____
		(please specify)
- other reason:	<input type="checkbox"/>	

(please specify)

medication sheet no. ____ of ____

MEDICATION HISTORY WITHIN 1 MONTH BEFORE HOSPITALIZATION

date of admission

no drug use

☐

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

medication sheet no. ____ of ____

MEDICATION HISTORY WITHIN 1 MONTH BEFORE HOSPITALIZATION

date of admission

no drug use

☐

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, any adverse reaction

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, any adverse reaction

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
Indication		<input type="checkbox"/> <input type="checkbox"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>
			<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="checkbox"/>

previous intake

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, any adverse reaction

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes, please specify:

medication sheet no. ____ of ____

MEDICATION HISTORY WITHIN 1 MONTH BEFORE HOSPITALIZATION

date of admission

no drug use

☐

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
_____		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Indication			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
_____			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
_____		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Indication			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
_____			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

Drug	Dose	Type of application	Begin of intake day month year	End of intake day month year	Frequency
_____		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
Indication			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>
_____			<input type="text"/>	<input type="text"/>	<input type="checkbox"/>

previous intake

no ☐ yes ☐ unknown ☐

If yes, any adverse reaction

no ☐ yes ☐ unknown ☐

If yes, please specify:

--	--	--

--	--	--	--	--

Have you ever had an adverse reaction to drugs?

no

☐

yes

☐

unknown

☐

If yes,

Drug: _____

Type of reaction: _____

Drug: _____

Type of reaction: _____

Drug: _____

Type of reaction: _____

Drug: _____

Type of reaction: _____

Drug: _____

Type of reaction: _____

DISCHARGE SHEET

Interview no.

--	--	--

--	--	--	--	--

hospital no.

--	--	--	--	--

Discharge diagnoses

1. _____
2. _____
3. _____
4. _____
5. _____

Results of the present admission

1. Death

☐

date of death

--	--	--	--	--	--

2. Discharge

☐

date of discharge

--	--	--	--	--	--

Mycoplasma infection within
two months before admission

no

☐

yes

☐

unknown

☐

date of diagnosis

--	--	--	--	--	--

If yes, criteria:

☐ serology

☐ isolation

☐ x-ray

--	--	--

--	--	--	--	--

MAIN SOURCE OF INFORMATION

1) Clinical pattern of the reaction

	no	yes	unknown
* Were the skin lesions seen by the investigator in acute stage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If not, please provide the source
(e.g., family physician, dermatologist, nurse, family member)

2) Medication history

* just patient ☐

* just other source ☐

If yes, please specify:

* both ☐

If yes, please specify:

UNIT OF TREATMENT

1. Burn unit ☐

2. Dept. of dermatology ☐

3. Intensive care unit ☐

4. Pediatric department ☐

5. Internal medicine ☐

6. Other: ☐

(please specify)

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--	--	--	--	--

ADDITIONAL REMARKS

Please use the fields below to note important additional information.

Please stick to the predefined topics and avoid redundancy:

For cases and controls:

Here you can specify additional information regarding ethnic origin:

Only for cases:

Here you can specify if patient died after discharge before the follow-up or blood sampling.

Please specify date of death correspondingly:

Here you can specify any other reason why follow-up investigations/blood sampling could not be done:

Further relevant remarks (if agreed upon by Data Center):

Interview no.

THERAPY 1

TREATING HOSPITAL

hospital no.

--	--	--	--	--

date of admission

--	--	--	--	--	--	--

1. Burn unit ☐
2. Dept. of dermatology ☐
3. Intensive care unit ☐
4. Pediatric department ☐
5. Internal medicine ☐
6. Other: ☐

(please specify)

SYSTEMIC THERAPY

1) Corticosteroids

no

☐

yes

☐

unknown

☐

If yes,
please enter:

starting date

--	--	--	--	--	--	--

stopping date

--	--	--	--	--	--	--

Day 1 Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Day 2 Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Day 3 Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Day 4 Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Interview no.

THERAPY 2

2) IVIG

no yes unknown
☐ ☐ ☐

If yes,
please enter dates:

starting date stopping date

--	--	--	--	--	--

--	--	--	--	--	--

Day 1 Brand name: _____

Dosage: _____

Day 2 Brand name: _____

Dosage: _____

Day 3 Brand name: _____

Dosage: _____

Day 4 Brand name: _____

Dosage: _____

3) Other systemic treatments

no yes unknown
☐ ☐ ☐

If yes,
please enter:

starting date stopping date

--	--	--	--	--	--

--	--	--	--	--	--

Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Comment: _____

If yes,
please enter:

starting date stopping date

--	--	--	--	--	--

--	--	--	--	--	--

Brand name: _____

Dosage: _____ Application: p.o. ☐ i.v. ☐

Comment: _____

Interview no.

THERAPY 3

4) Antibiotics

no	yes	unknown
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If yes,

- Therapeutic use

☐

starting date

--	--	--	--	--	--	--	--

- Prophylactic use

☐

starting date

--	--	--	--	--	--	--	--

- Unknown indication

☐

starting date

--	--	--	--	--	--	--	--

TRANSFER TO OTHER HOSPITAL OR DEPARTMENT FOR TREATMENT OF SCAR

no	yes
<input type="checkbox"/>	<input type="checkbox"/>

If yes, please complete the sheet for the second treating hospital.