THYROID EYE DISEASE PROFORMA

Hospital name: Hospital code:

Doctor:

☐ New ☐ Old

A. Demographics

Serial No: Date of Examination:

Name: Age (Years):

Gender: ☐ Male ☐ Female ☐ Prefer not to say

Address (Province): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7

Phone Number: Occupation:

Chief Complaint: ☐ Foreign Body Sensation ☐ Discomfort in Eye ☐ Eyelid Swelling ☐ Watering ☐ Redness ☐ Blurring of Vision ☐ Protrusion of Eyeball ☐ Reading Problem ☐ Double Vision ☐ **spontaneous pain** ☐ **Gaze evoked pain** ☐ Asymptomatic (Noticed by relatives/friends)

Duration of symptoms: Family History: ☐ Thyroid Disorder ☐ TED ☐ Myasthenia Gravis

Personal History: ☐ DM ☐ HTN ☐ Myasthenia Gravis ☐ Hyperlipidemia ☐ Smoking (☐ Passive Smoker ☐ No ☐ Packets/day)

Thyroid Status: ☐ Hyperthyroid ☐ Hypothyroid ☐ Euthyroid

B. Examination

Visual Acuity (Snellen):

UCVA: OD ___ OS ___

BCVA: OD ___ OS ___

Pupillary Examination (RAPD): ☐ Present (OD/OS) ☐ Absent

Extraocular Movements (EOM): ☐ Full Range ☐ Limited (OD/OS/OU)

Eyelid Signs: OD ☐ Vertical fissure height (_mm) ☐ Lid Lag ☐ **Lid Edema** ☐ Tremors on Lid Closure ☐ **Eyelid Erythema** ☐ Lagophthalmos (___ mm) ☐ MRD1 ___ mm☐ MRD2 ___ mm ☐ Lateral flare

OS ☐ Vertical fissure height (_mm) ☐ Lid Lag ☐ **Lid Edema** ☐ Tremors on Lid Closure ☐ **Eyelid Erythema** ☐ Lagophthalmos (___ mm) ☐ MRD1 ___ mm☐ MRD2 ___ mm ☐ Lateral flare

Proptosis: ☐ Yes(OD/OS/OU) ☐ No

If Yes: ☐ Painful ☐ Painless ☐ Axial ☐ Non-Axial ☐ Progressive ☐ Non-Progressive ☐ Pulsatile ☐ Non-Pulsatile ☐ Retrobulbar Resistance ☐ Periorbital Changes

Hertel's Reading: Base ___ mm OD ___ mm OS ___ mm / Ruler method: OD ___ mm OS ___ mm

Anterior Segment Examination: ☐ **Congestion** at Extraocular Muscle Insertion ☐ Superior Limbic Keratoconjunctivitis ☐ SPKs ☐ Corneal Ulcer ☐ **Chemosis** ☐ **Caruncular** Congestion ☐ Others:

OD Disc edema ☐ OS Disc edema ☐

C. Investigations

Schirmer Test 1: ☐ Not Done ☐ <5mm ☐ 5-10mm ☐ >10mm

Thyroid Function Test/Antibody Test: TSH ___ FT3 ___ FT4 ___ TSHR Ab ___ TSI ___TPO

Lipid Profile Test: ☐ Not Done ☐ Normal ☐ Abnormal

Serum Vitamin D Level: ☐ Not Done ☐ Normal ☐ Abnormal

Color vision: ☐ Not Done ☐ Normal ☐ Abnormal

Visual Field: ☐ Not Done ☐ Normal ☐ Abnormal

CT Orbit: ☐ Not Done ☐ Normal ☐ Fat-Predominant Type ☐ Muscle-Predominant Type ☐ Mixed Fat & Muscle ☐ Crowding Apex. MRI: ☐ Not Done ☐ Normal ☐ inflamed EOM ☐crowding of apex

D. Diagnosis

Thyroid Status: ☐ Euthyroid ☐ Hypothyroid ☐ Hyperthyroid

Clinical Activity Score: ……/7 or ……./10

Severity ☐ Mild ☐ moderate -severe ☐ sight threatening DON ☐ sight threatening corneal exposure

E. Management

Previous Treatment:

☐ Thyroid Hormone Replacement ☐ β-Blockers ☐ Carbimazole/Methimazole/Propylthiouracil ☐ Corticosteroids (Oral/IV) ☐ Selenium/Vitamin D ☐ Anti-Lipid Agent ☐ Anti-Diabetic Agent ☐ Anti-Hypertensive Agent ☐ Immunomodulators ☐ others…..

Radioactive Iodine Therapy: ☐ Yes ☐ No. Injection Botulinum Toxin: ☐ Yes ☐ No

Injection Tricort: ☐ Yes ☐ No Blepharotomy: ☐ Yes ☐ No

Current Treatment Plan:

Topical Therapy: ☐ Lubricating Drops ☐ NSAIDS ☐ oral selenium

Systemic Therapy: ☐ Corticosteroids (Oral/IVMP/Local) ☐ immunomodulators (Azathioprine/ Mycophenolate)

Radiotherapy: ☐ Yes ☐ No

Surgical Therapy: ☐ Lateral Tarsorrhaphy ☐ Squint Surgery ☐ Blepharotomy ☐ Ptosis Correction ☐ Blepharoplasty ☐ others….

Orbital Decompression: ☐ Fat Removal (FROD) ☐ Bone Removal (BROD) ☐ 1-Wall ☐ 2-Wall ☐ 3-Wall ☐ 4-Wall

F. Graves Orbitopathy Quality of Life Questionnaire (GO-QOL)

Instructions: Tick the box that matches your answer. Please tick only one box for each question.

Question	Seriously	A little	Not at all
1. Bicycling (if applicable)	☐	☐	☐
2. Driving (if applicable)	☐	☐	☐
3. Moving around the house	☐	☐	☐
4. Walking outdoors	☐	☐	☐
5. Reading	☐	☐	☐
6. Watching TV	☐	☐	☐
7. Engaging in hobbies or pastimes	☐	☐	☐
8. During the past week, did TED hinder you from something you wanted to do?	☐	☐	☐

Appearance and Social Impact

Question	Yes, very much	Yes, a little	No
9. Has your appearance changed due to TED?	☐	☐	☐
10. Do you feel stared at in public because of TED?	☐	☐	☐
11. Do people react unpleasantly to your appearance?	☐	☐	☐
12. Has TED affected your self-confidence?	☐	☐	☐
13. Do you feel socially isolated due to TED?	☐	☐	☐
14. Has TED affected your ability to make friends?	☐	☐	☐
15. Do you appear in photos less often than before TED?	☐	☐	☐
16. Do you try to mask your appearance changes caused by TED?	☐	☐	☐

स्वीकृति फारम (Consent Form)

नेपाल थाइरॉइड आँखा रोग दर्ता कार्यक्रम (Nepal Thyroid Eye Disease Registry)

रोगीको नाम
सम्पर्क नम्बर
ठेगाना

म, माथि उल्लेखित व्यक्ति, नेपाल थाइरॉइड आँखा रोग दर्ता कार्यक्रममा आफ्नो स्वतन्त्र इच्छा र सहमतिसाथ सहभागी हुन चाहन्छु।
मलाई यस कार्यक्रमको उद्देश्य, प्रक्रिया, संलग्नता, गोपनीयता, सम्भावित फाइदा तथा जोखिमहरूबारे स्पष्ट जानकारी दिइएको छ।
विशेषतः
१) मेरो रोगसम्बन्धी विवरण, उपचार विवरण, तथा आँखा जाँचको नतिजाहरू दर्ता फारममा संकलन गरिनेछ।
२) संकलित विवरण अनुसन्धान तथा आँखा स्वास्थ्य सेवाको सुधारको उद्देश्यका लागि मात्र प्रयोग गरिनेछ।
३) मेरो व्यक्तिगत परिचय खुलाउने जानकारी गोप्य राखिनेछ।
४) यो कार्यक्रममा सहभागिता स्वेच्छिक हो, र म जुनसुकै समयमा बिना कारण सहभागिता फिर्ता लिन सक्दछु।
५) यस अनुसन्धानबाट मलाई प्रत्यक्ष फाइदा नहुन सक्छ, तर आगामी बिरामीहरूको उपचारमा उपयोगी हुन सक्छ।
मैले माथिका सबै बुँदाहरू बुझें र मलाई थप जानकारी आवश्यक परेमा सोध्न अनुमति दिइएको छ।

रोगी प्रतिनिधिको विवरण/ स्वीकृति दिने व्यक्ति
नाम
हस्ताक्षर
मिति

अनुसन्धानकर्ताको विवरण /क्लिनिकल टीम सदस्य
नाम
पद
संस्थान
हस्ताक्षर
मिति

दायाँ | बायाँ