

GI Subtype			
<input type="checkbox"/> Autoimmune		<input type="checkbox"/> HLH	
<input type="checkbox"/> Autoinflammatory		<input type="checkbox"/> SCID	
<input type="checkbox"/> CVID & CID			
Autoimmune Disease			
Age of onset:		Psychosis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Malar rash	Yes <input type="checkbox"/> No <input type="checkbox"/>	Seizures	Yes <input type="checkbox"/> No <input type="checkbox"/>
Photosensitivity	Yes <input type="checkbox"/> No <input type="checkbox"/>	Proteinuria	Yes <input type="checkbox"/> No <input type="checkbox"/>
Alopecia	Yes <input type="checkbox"/> No <input type="checkbox"/>	Glomerulonephritis (on biopsy)	Yes <input type="checkbox"/> No <input type="checkbox"/>
Aphthous ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Lymphocyte count: _____ (x10 ⁹ /L)	
Arthritis	Yes <input type="checkbox"/> No <input type="checkbox"/>	White cell count: _____ (x10 ⁹ /L)	
Serositis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Platelet count: _____ (x10 ⁹ /L)	
Antinuclear antibodies: _____ (titre)			
dsDNA antibodies	Yes <input type="checkbox"/> No <input type="checkbox"/>	CNS vasculitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sm antibodies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autoimmune gastritis/pernicious anaemia	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cardiolipin antibodies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autoimmune thyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
B2 glycoprotein 1 antibodies	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autoimmune parathyroid disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Lupus anticoagulant	Yes <input type="checkbox"/> No <input type="checkbox"/>	Autoimmune adrenalitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low C3	Yes <input type="checkbox"/> No <input type="checkbox"/>	Hypophysitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Low C4	Yes <input type="checkbox"/> No <input type="checkbox"/>	Gonadal failure	Yes <input type="checkbox"/> No <input type="checkbox"/>
Pneumonitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Inflammatory bowel disease	Yes <input type="checkbox"/> No <input type="checkbox"/>
Autoimmune liver disease	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Treatment:			
Steroids (equivalent to >1mg/kg prednisone)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Rituximab	Yes <input type="checkbox"/> No <input type="checkbox"/>
Azathioprine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Abatacept	Yes <input type="checkbox"/> No <input type="checkbox"/>
Mycophenolate	Yes <input type="checkbox"/> No <input type="checkbox"/>	Other Mab	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cyclophosphamide	Yes <input type="checkbox"/> No <input type="checkbox"/>		
Autoinflammatory Disease			
Recurrent fevers: (Number)		Serositis:	<input type="checkbox"/> Pleuris <input type="checkbox"/> Pericarditis <input type="checkbox"/> Peritonitis
Pharyngitis	Yes <input type="checkbox"/> No <input type="checkbox"/>	Amyloidosis:	<input type="checkbox"/> Kidney <input type="checkbox"/> Skin <input type="checkbox"/> Other
Aphthous ulcers	Yes <input type="checkbox"/> No <input type="checkbox"/>	Erysipelas-like erythema	Yes <input type="checkbox"/> No <input type="checkbox"/>
Neutrophil count: _____ (x10 ⁹ /L)		C-reactive protein (while afebrile) _____ (mg/L)	
Urticaria	Yes <input type="checkbox"/> No <input type="checkbox"/>	Musculoskeletal symptoms	Yes <input type="checkbox"/> No <input type="checkbox"/>
Cold-induced manifestations	Yes <input type="checkbox"/> No <input type="checkbox"/>	Aseptic meningitis	Yes <input type="checkbox"/> No <input type="checkbox"/>
Stress-induced manifestations	Yes <input type="checkbox"/> No <input type="checkbox"/>	Splenomegaly	Yes <input type="checkbox"/> No <input type="checkbox"/>
Sensorineural hearing loss	Yes <input type="checkbox"/> No <input type="checkbox"/>	Response to colchicine	Yes <input type="checkbox"/> No <input type="checkbox"/>
Common Variable Immunodeficiency (CVID)/Combined Immune Deficiency (CID)			
Bacterial infection:	<input type="checkbox"/> Pneumonia <input type="checkbox"/> Meningitis <input type="checkbox"/> Sinusitis	Autoimmune cytopenia:	<input type="checkbox"/> Anaemia <input type="checkbox"/> Thrombocytopenia

Opportunistic infections: <input type="checkbox"/> PJP <input type="checkbox"/> Mucocutaneous candidiasis <input type="checkbox"/> Low virulence mycobacteria <input type="checkbox"/> Disseminated viral infection			Other autoimmunity/inflammation: <input type="checkbox"/> Pneumonitis <input type="checkbox"/> Colitis <input type="checkbox"/> Coeliac disease <input type="checkbox"/> Thyroiditis <input type="checkbox"/> Adrenalitis <input type="checkbox"/> Hypophysitis <input type="checkbox"/> Arthritis		
Granulomas: _____		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
IgG: _____ (g/L)					
IgM: _____ (g/L)					
IgA: _____ (g/L)					
Lymphocyte count: _____ (x 10 ⁹ /L)			Neutrophil count: _____ (x 10 ⁹ /L)		
CD19+ B cell count: _____ (x 10 ⁹ /L)			CD3+ T cell count: _____ (x 10 ⁹ /L)		
Immunoglobulin replacement		Yes <input type="checkbox"/>	No <input type="checkbox"/>		
Hemophagocytic Lymphohistiocytosis (HLH)					
Fever: _____ °C					
Splenomegaly: Yes <input type="checkbox"/> No <input type="checkbox"/>					
Haemoglobin: _____ (g/L)					
Haemophagocytosis:					
Bone marrow:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	ND <input type="checkbox"/>	
Spleen:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	ND <input type="checkbox"/>	
Platelets: _____ (x 10 ⁹ /L)			Neutrophil count: _____ (x 10 ⁹ /L)		
Triglycerides (fasting) - Please check yes to enter data if applicable. Yes <input type="checkbox"/> ND <input type="checkbox"/>			Fibrinogen - Please check yes to enter data if applicable. Yes <input type="checkbox"/> ND <input type="checkbox"/>		
Triglycerides (fasting): _____ (mmol/L)			Fibrinogen: _____ (mg/dL)		
Ferritin - Please check yes to enter data if applicable. Yes <input type="checkbox"/> ND <input type="checkbox"/>			Serum CD25 - Please check yes to enter data if applicable. Yes <input type="checkbox"/> ND <input type="checkbox"/>		
Fibrinogen: _____ (ng/mL)			Serum CD25: _____ (U/ mL)		
Absent NK cell cytotoxicity:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	ND <input type="checkbox"/>	
High suspicion of CNS involvement:		Yes <input type="checkbox"/>		No <input type="checkbox"/>	
Herpesvirus infection:			Associated clinical syndrome:		
HSV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Autoimmune disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	
EBV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Malignancy		<input type="checkbox"/> Yes <input type="checkbox"/> No	
VZV	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metabolic disease		<input type="checkbox"/> Yes <input type="checkbox"/> No	
HHV6	<input type="checkbox"/> Yes <input type="checkbox"/> No	Leishmania infection		<input type="checkbox"/> Yes <input type="checkbox"/> No	
HHV8	<input type="checkbox"/> Yes <input type="checkbox"/> No				
Treatment:					
Corticosteroids		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Etoposide		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Cyclosporin		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Antithymocyte globulin		<input type="checkbox"/> Yes <input type="checkbox"/> No			
Severe Combined Immunodeficiency (SCID)					
CD3+ T cells: _____ (x10 ⁶ /L)			CD3+ CD45RO+ T cells: _____ (%CD3+ cells)		
Maternal T cells:		Yes <input type="checkbox"/> No <input type="checkbox"/>			
T cell proliferation Mitogen: _____ (%)			T cell proliferation Antigen: _____ (%)		
Neutrophil count: _____ (x10 ⁶ /L)					

Erythroderma:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>
Sensorineural deafness:	Yes	<input type="checkbox"/>	No	<input type="checkbox"/>