Assignment 11

Problem: There has been a call for data collection around sexually transmitted diseases. Many nations struggle with decision-making as the data available needs to be more informative and include essential fields. For this assignment and the rest of the course, we will work with the CDC standard forms to create a data collection – case reporting system for chlamydia and gonorrhea, congenital syphilis, and Hepatitis B. This is to make the front-end problem-specific design where we enforce rules on the form fields to ensure complete and accurate data collection. Three forms have been attached for you. You must draft a system framework for this assignment, create your directory structure, and make the forms. The workflow recommended is to have

1. A login form on the index page from where authorized users logs in. (10 marks)
2. <!DOCTYPE html>
3. <html>
4. <head>
5. <meta charset="utf-8">
6. <meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>
7. <meta name ="description" content ="Dynamic web development">
8. <meta name = "author" content ="lawrence">
9. <meta name = "viewport" content ="width=device-width,initial-scale=1.0">
10. <title>grid view layout</title>
11. <link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">
12. <link rel ="stylesheet" type ="text/css" href ="../css/main.css">
14. </head>
15. <body>
16. <h1>LOGIN PAGE</h1>
17. <nav>
18. <ul>
20. <li><a href ="30.html">LOGIN</a></li>
22. </ul>
23. </nav>
25. </body>
26. </html>

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>float Layout</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css"/>

<link rel ="stylesheet" href ="css/main.css">

</head>

<body>

      <h1>welcome to my page</h1>

      <form action=

        <div class="form-group">

            <label>Username</label>

            <input type="text" name="username"

        </div>

        <div class="form-group">

            <label>Password</label>

            <input type="password" name="password"

        </div>

        <div class="form-group">

            <label>Confirm Password</label>

            <input type="password" name="confirm\_password"

        </div>

        <div class="form-group">

            <input type="submit" value="Submit">

            <input type="reset" value="Reset">

        </div>

        <p>Already have an account? <a href="login">Login here</a>.</p>

    </form>

</div>

</body>

</html>

2. A registration form where each client/patient is registered. This form will be access-controlled and should not be in the root directory. This should collect personal information like names (optional), unique Identifier (required), sex (required), gender identity (required), Sexual Orientation (required), and date of birth (Only the year of birth is required.) (20 marks)

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>Html forms</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">

<link rel ="stylesheet" type ="text/css" href ="../css/main.css">

</head>

<body>

<h1>Html forms</h1>

<form>

    <label for ="firstname">Firstname:</label><br/>

    <input id ="firstname" name ="firstname" type ="text"/><br/>

    <label for ="othername">othername:</label><br/>

    <input id ="othername" name ="othername" type ="text"/><br/>

    <label for ="lastname">lastname:</label><br/>

    <input id ="lastname" name ="lastname" type ="text"/><br/>

    <label for="uniqueid">Unique ID</label><br/>

    <input type ="password" id ="uniqueid" name ="uniqueid"><br/>

     <label for ="year">Select year</label>

    <input type ="year" name ="year" id ="year"/><br/>

    <label>Sex</label><br/>

    <input type ="radio" name ="sex" value ="female" id ="Female">

    <label for ="Female">Female</label>

    <input type ="radio" name ="sex" value ="Male" id ="Male">

    <label for ="Male">Male</label>

    <input type ="radio" name ="sex" value ="intersex" id ="intersex">

    <label for ="intersex">intersex</label><br/>

    <label>Gender Identity</label><br/>

    <input type ="radio" name ="gender identity" value ="cisgender" id ="cisgender">

    <label for ="cisgender">Cisgender</label>

    <input type ="radio" name ="gender identity" value ="Gender Expression" id ="Gender Expression">

    <label for ="Gender Expression">Gender Expression</label>

    <input type ="radio" name ="gender identity" value ="Gender Fluid" id ="Gender fluid">

    <label for ="Gender fluid">Gender Fluid</label>

    <input type ="radio" name ="gender identity" value ="Genderqueer" id ="Genderqueer">

    <label for ="Genderqueer">Genderqueer</label>

    <input type ="radio" name ="gender identity" value ="Gender Variant" id ="Gender Variant">

    <label for ="Gender variant">Gender Variant</label>

    <input type ="radio" name ="gender identity" value ="Mx" id ="Mx">

    <label for ="Mx">Mx</label><br/>

    <label for="sexorientation">Sexual Orientation</label><br/>

    <select id ="sexorientation" name ="sexorientation">

    <option selected disabled>[Select one]</option>

    <option value ="heterosexual">Heterosexual</option>

    <option value ="homosexual">Homosexual</option>

    <option value ="bisexual">bisexual</option>

    <option value ="other">Other</option>

    <input type ="reset" name ="reset"/>

    <input type ="submit" value ="submit"/>

</form>

</body>

</html>

Note: when dealing with the year of birth there will be no year to select unless written down in the box space while dealing with month and time there is always option to select from.

3. A logged-in user should retrieve the client/patient page, with a side navigation holding 5 links to pages. And top navigation with the home and logout link to the right end of the page. Each of the side navigation will contain a form (40 marks).

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>float Layout</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css"/>

<link rel ="stylesheet" href ="css/main.css">

</head>

<body>

      <h1>welcome to my page</h1>

      <form action=

        <div class="form-group">

            <label>Username</label>

            <input type="text" name="username"

        </div>

        <div class="form-group">

            <label>Password</label>

            <input type="password" name="password"

        </div>

        <div class="form-group">

            <label>Confirm Password</label>

            <input type="password" name="confirm\_password"

        </div>

        <div class="form-group">

            <input type="submit" value="Submit">

            <input type="reset" value="Reset">

        </div>

        <p>Already have an account? <a href="40.html">Login here</a>.</p>

    </form>

</div>

</body>

</html>

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>float Layout</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css"/>

<link rel ="stylesheet" href ="css/main.css">

</head>

<body>

<h1>HOME PAGE</h1>

    <nav>

        <ul>

            <li><a href ="30.html">HOME</a></li>

            <li><a href ="pages/50.html">REGISTRATION FORM</a></li>

            <li><a href ="pages/60.html">RISK FACTOR INFORMATION</a></li>

            <li><a href ="pages/70.html">HEPATITIS B PREGNANT WOMEN REPORTING FORM</a></li>

            <li><a href ="pages/80.html">CONGENTIAL SYPHILLS FORM</a></li>

            <li><a href ="pages/90.html">CHLAMYDIA AND GONORRHEA CASE REPORTING FORM</a></li>

            <li><a href ="30.html">LOGOUT</a></li>

        </ul>

    </nav>

    </body>

    </html>

1. Form 1 / Navigation 1 = Personal Information form with all the registration information collected. Create this form to be an editable form of the registration form. Since we are not creating the functionality but just the front-end design, replicate the registration form here.
2. <!DOCTYPE html>
3. <html>
4. <head>
5. <meta charset="utf-8">
6. <meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>
7. <meta name ="description" content ="Dynamic web development">
8. <meta name = "author" content ="lawrence">
9. <meta name = "viewport" content ="width=device-width,initial-scale=1.0">
10. <title>REGISTRATION FORM</title>
11. <link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">
12. <link rel ="stylesheet" type ="text/css" href ="../css/main.css">
14. </head>
15. <body>
16. <h1>REGISTRATION FORM</h1>
17. <form>
18. <label for ="firstname">Firstname:</label><br/>
19. <input id ="firstname" name ="firstname" type ="text"/><br/>
20. <label for ="othername">othername:</label><br/>
21. <input id ="othername" name ="othername" type ="text"/><br/>
22. <label for ="lastname">lastname:</label><br/>
23. <input id ="lastname" name ="lastname" type ="text"/><br/>
24. <label for="uniqueid">Unique ID</label><br/>
25. <input type ="password" id ="uniqueid" name ="uniqueid"><br/>
26. <label for ="month">Select month</label>
27. <input type ="month" name ="month" id ="month"/><br/>
28. <label>Sex</label><br/>
29. <input type ="radio" name ="sex" value ="female" id ="Female">
30. <label for ="Female">Female</label>
31. <input type ="radio" name ="sex" value ="Male" id ="Male">
32. <label for ="Male">Male</label>
33. <input type ="radio" name ="sex" value ="intersex" id ="intersex">
34. <label for ="intersex">intersex</label><br/>
35. <label>Gender Identity</label><br/>
36. <input type ="radio" name ="gender identity" value ="cisgender" id ="cisgender">
37. <label for ="cisgender">Cisgender</label>
38. <input type ="radio" name ="gender identity" value ="Gender Expression" id ="Gender Expression">
39. <label for ="Gender Expression">Gender Expression</label>
40. <input type ="radio" name ="gender identity" value ="Gender Fluid" id ="Gender fluid">
41. <label for ="Gender fluid">Gender Fluid</label>
42. <input type ="radio" name ="gender identity" value ="Genderqueer" id ="Genderqueer">
43. <label for ="Genderqueer">Genderqueer</label>
44. <input type ="radio" name ="gender identity" value ="Gender Variant" id ="Gender Variant">
45. <label for ="Gender variant">Gender Variant</label>
46. <input type ="radio" name ="gender identity" value ="Mx" id ="Mx">
47. <label for ="Mx">Mx</label><br/>
48. <label for="sexorientation">Sexual Orientation</label><br/>
49. <select id ="sexorientation" name ="sexorientation">
50. <option selected disabled>[Select one]</option>
51. <option value ="heterosexual">Heterosexual</option>
52. <option value ="homosexual">Homosexual</option>
53. <option value ="bisexual">bisexual</option>
54. <option value ="other">Other</option>


58. </form>

61. </body>
62. </html>

b. Form 2 / Navigation 2 = Risk Factor Information (No form provided; create a page for it)

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>REGISTRATION FORM</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">

<link rel ="stylesheet" type ="text/css" href ="../css/main.css">

</head>

<body>

<h1>RISK FACTOR INFORMATION</h1>

<form>

    <label for ="lastname">Lastname:</label>

    <input id ="lastname" name ="lastname" type ="text"/>

    <label for ="firstname">Firstname:</label>

    <input id ="firstname" name ="firstname" type ="text"/>

    <label for ="middlename">middlename:</label>

    <input id ="middlename" name ="middlename" type ="text"/><br/>

    <label for="dob">Date Of Birth</label>

    <input type ="date" id ="dob" name ="dob">

    <label>Sex</label><br/>

    <input type ="radio" name ="sex" value ="female" id ="Female">

    <label for ="Female">Female</label>

    <input type ="radio" name ="sex" value ="Male" id ="Male">

    <label for ="Male">Male</label>

    <input type ="radio" name ="sex" value ="intersex" id ="intersex">

    <label for ="intersex">intersex</label><br/>

    <label>Gender Identity</label><br/>

    <input type ="radio" name ="gender identity" value ="cisgender" id ="cisgender">

    <label for ="cisgender">Cisgender</label>

    <input type ="radio" name ="gender identity" value ="Gender Expression" id ="Gender Expression">

    <label for ="Gender Expression">Gender Expression</label>

    <input type ="radio" name ="gender identity" value ="Gender Fluid" id ="Gender fluid">

    <label for ="Gender fluid">Gender Fluid</label>

    <input type ="radio" name ="gender identity" value ="Genderqueer" id ="Genderqueer">

    <label for ="Genderqueer">Genderqueer</label>

    <input type ="radio" name ="gender identity" value ="Gender Variant" id ="Gender Variant">

    <label for ="Gender variant">Gender Variant</label>

    <input type ="radio" name ="gender identity" value ="Mx" id ="Mx">

    <label for ="Mx">Mx</label><br/>

    <label>Risk factors in health and Disease</label><br/>

    <input type ="radio" name ="Risk factors in health and Disease" value ="behavioural" id ="behavioural">

    <label for ="behavioural">behavioural</label><br/>

    <input type ="radio" name ="Risk factors in health and Disease" value ="physiological" id ="physiological">

    <label for ="physiological">physiological</label><br/>

    <input type ="radio" name ="Risk factors in health and Disease" value ="demographical" id ="demographical">

    <label for ="demographical">demographical</label><br/>

    <input type ="radio" name ="Risk factors in health and Disease" value ="Environmental" id ="Environmental">

    <label for ="Environmental">Environmental</label><br/>

</form>

</body>

</html>

c. Form 3 / Navigation 3 = Hepatitis B Pregnant Women Reporting form

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>REGISTRATION FORM</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">

<link rel ="stylesheet" type ="text/css" href ="../css/main.css">

</head>

<body>

<h1>HEPATITIS B INFECTED PREGNANT WOMAN REPORTING FORM</h1>

<form>

    <label for ="lastname">Lastname:</label>

    <input id ="lastname" name ="lastname" type ="text"/>

    <label for ="firstname">Firstname:</label>

    <input id ="firstname" name ="firstname" type ="text"/>

    <label for ="middlename">middlename:</label>

    <input id ="middlename" name ="middlename" type ="text"/><br/>

    <label for="dob">Date Of Birth</label>

    <input type ="date" id ="dob" name ="dob">

    <label for = "datetime"> Estimated delivery date</label>

    <input type ="datetime-local" name ="datetime" id="datetime"/>

    <label>patient aware of HepB+ status?</label>

    <input type ="radio" name ="patient aware of HepB+ status" value ="yes" id ="yes">

    <label for ="yes">yes</label>

    <input type ="radio" name ="patient aware of HepB+ status" value ="no" id ="no">

    <label for ="no">no</label>

    <input type ="radio" name ="patient aware of HepB+ status" value ="unk" id ="unk">

    <label for ="unk">unk</label><br/>

    <label for ="address">Address:</label>

    <input id ="address" name ="address" type ="text"/>

    <label for ="city">city:</label>

    <input id ="city" name ="city" type ="text"/>

    <label for ="state">State:</label>

    <input id ="state" name ="state" type ="text"/>

    <label for ="zip">zip:</label>

    <input id ="zip" name ="zip" type ="text"/><br/>

    <label for ="tel">telephone</label>

    <input type = "tel" name ="tel" id ="tel"/>

    <label>type of insurance:</label>

    <input type ="radio" name ="type of insurance" value ="private" id ="private">

    <label for ="private">private</label>

    <input type ="radio" name ="type of insurance" value ="medicaid" id ="medicaid">

    <label for ="medicaid">medicaid</label>

    <input type ="radio" name ="type of insurance" value ="medicare" id ="medicare">

    <label for ="medicare">medicare</label>

    <input type ="radio" name ="type of insurance" value ="uninsured" id ="uninsured">

    <label for ="uninsured">uninsured</label>

    <input type ="radio" name ="type of insurance" value ="unknown" id ="unknown">

    <label for ="unknown">unknown</label><br/>

    <label>Race:</label><br/>

    <input type ="radio" name ="race" value ="American Indian/Alaskan Native" id ="American Indian/Alaskan Native">

    <label for ="American Indian/Alaskan Native">American Indian/Alaskan Native</label>

    <input type ="radio" name ="race" value ="Native Hawaiian/Pacific Islander" id ="Native Hawaiian/Pacific Islander">

    <label for ="Native Hawaiian/Pacific Islander">Native Hawaiian/Pacific Islander</label>

    <input type ="radio" name ="race" value ="Asian" id ="Asian">

    <label for ="Asian">Asian</label>

    <input type ="radio" name ="race" value ="White" id ="White">

    <label for ="White">White</label>

    <input type ="radio" name ="race" value ="Black/African Am." id ="Black/African Am.">

    <label for ="Black/African Am.">Black/African Am.</label>

    <input type ="radio" name ="race" value ="Unk" id ="Unk">

    <label for ="Unk">Unk</label>

    <input type ="radio" name ="race" value ="Other" id ="Other">

    <label for ="Other">Other</label><br/>

    <label>Hispanic:</label><br/>

    <input type ="radio" name ="hispanic" value ="yes" id ="yes">

    <label for ="Yes">Yes</label>

    <input type ="radio" name ="hispanic" value ="No" id ="No">

    <label for ="No">No</label>

    <input type ="radio" name ="hispanic" value ="unk" id ="unk">

    <label for ="unk">unk</label><br/>

    <label for ="Country of Birth">Country of Birth:</label>

    <input id ="Country of Birth" name ="Country of Birth" type ="text"/>

    <label for ="primary Language">Primary Language:</label>

    <input id ="primary language" name ="primary language" type ="text"/><br/>

    <label for ="check if interpreter is needed">check if interpreter is needed</label>

    <input type ="radio" name ="check if interpreter is needed" value ="check if interpreter is needed" id ="check if interpreter is needed"><br/>

    <h2>Laboratory Information</h2>

    <label> Laboratory Results: Check off below any POSITIVE labs and attach positive Hep B lab results</label><br/>

    <input type ="radio" name =" Laboratory Results" value ="HBsAg (Hep B surface antigen)" id ="HBsAg (Hep B surface antigen)">

    <label for ="HBsAg (Hep B surface antigen)">HBsAg (Hep B surface antigen)</label><br/>

    <input type ="radio" name =" Laboratory Results" value ="IgM anti-HBc (IgM antibody to Hep B core antigen)" id ="IgM anti-HBc (IgM antibody to Hep B core antigen)">

    <label for ="IgM anti-HBc (IgM antibody to Hep B core antigen)">IgM anti-HBc (IgM antibody to Hep B core antigen)</label><br/>

    <input type ="radio" name =" Laboratory Results" value ="HBeAg (Hep Be antigen)" id ="HBeAg (Hep Be antigen)">

    <label for ="HBeAg (Hep Be antigen)">HBeAg (Hep Be antigen)</label><br/>

    <input type ="radio" name =" Laboratory Results" value ="HBV DNA (Hep B virus DNA)" id ="HBV DNA (Hep B virus DNA)">

    <label for ="HBV DNA (Hep B virus DNA)">HBV DNA (Hep B virus DNA)</label><br/>

    <h3>Clincal information</h3>

    <label for ="Obproviderlasttname">Ob provider lastname:</label>

    <input id ="obproviderlastname" name ="obproviderlastname" type ="text"/>

    <label for ="Obproviderfirstname">Ob provider firstname:</label>

    <input id ="obproviderfirstname" name ="obproviderfirstname" type ="text"/>

    <label>Provider Type</label>

    <input type ="radio" name ="provider Type" value ="MD/DO" id ="MD/DO">

    <label for ="MD/DO">MD/DO</label>

    <input type ="radio" name ="provider Type" value ="CNM/NP" id ="CNM/NP">

    <label for ="CNM/NP">CNM/NP</label>

    <input type ="radio" name ="provider Type" value ="PA" id ="PA">

    <label for ="PA">PA</label><br/>

    <label for ="Expected Delivery Facility">Expected Delivery Facility:</label>

    <input id ="Expected Delivery Facility" name ="Expected Delivery Facility" type ="text"/><br/>

    <label for ="Reporting Health Care Facility">Reporting Health Care Facility:</label>

    <input id ="Reporting Health Care Facility" name ="Reporting Health Care Facility" type ="text"/><br/>

    <label for ="address">Address:</label>

    <input id ="address" name ="address" type ="text"/>

    <label for ="city">city:</label>

    <input id ="city" name ="city" type ="text"/>

    <label for ="state">State:</label>

    <input id ="state" name ="state" type ="text"/>

    <label for ="zip">zip:</label>

    <input id ="zip" name ="zip" type ="text"/><br/>

    <label for ="Contact Person at Reporting Facility">Contact Person at Reporting Facility:</label>

    <input id ="Contact Person at Reporting Facility" name ="Contact Person at Reporting Facility" type ="text"/><br/>

    <label for ="tel">Direct phone:</label>

    <input type = "tel" name ="tel" id ="tel"/>

    <label for =" Date Form Completed"> Date Form Completed:</label>

    <input id =" Date Form Completed" name =" Date Form Completed" type ="text"/>

    <label for ="Positive Labs Attached">Positive Labs Attached:</label>

    <input id =" Positive Labs Attached" name ="Positive Labs Attached" type ="text"/>

</form>

</body>

</html>

d. Form 4 / Navigation 4 = Congenital Syphilis Form

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>Congenital Syphilis Form </title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">

<link rel ="stylesheet" type ="text/css" href ="../css/main.css">

</head>

<body>

    <h1>Congenital Syphilis Form</h1>

<form>

    <p>1. Report date to health dept. 9 ❑ Unk </p>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label for ="Reporting state FIPS code: 9 ❑ Unk ">2.Reporting state FIPS code: 9 ❑ Unk :</label>

    <input id ="Reporting state FIPS code: 9 ❑ Unk " name ="Reporting state FIPS code: 9 ❑ Unk " type ="text"/><br/>

    <label for =" Reporting county FIPS code: 9 ❑ Unk ">3. Reporting county FIPS code: 9 ❑ Unk :</label>

    <input id =" Reporting county FIPS code: 9 ❑ Unk " name =" Reporting county FIPS code: 9 ❑ Unk " type ="text"/><br/>

    <p>Reporting County Name</p>

    <p> Part I. Maternal InforMatIon </p>

   <label for ="Mother’s state FIPS code: 9 ❑ Unk ">4.Mother’s state FIPS code: 9 ❑ Unk :</label>

    <input id ="Mother’s state FIPS code: 9 ❑ Unk " name ="Mother’s state FIPS code: 9 ❑ Unk " type ="text"/><br/>

    <p>Mother’s Residence State</p>

    <label for ="Mother’s Country of residence: ">5. Mother’s Country of residence:</label>

    <input id =" 5. Mother’s Country of residence: " name ="Mother’s Country of residence: " type ="text"/><br/>

    <p>(leave blank if USA) Mother’s Country of Residence</p>

    <label for ="Mother’s residence county FIPS code: 9 ❑ Unk ">6.Mother’s residence county FIPS code: 9 ❑ Unk :</label>

    <input id ="6. Mother’s residence county FIPS code: 9 ❑ Unk " name ="6. Mother’s residence county FIPS code: 9 ❑ Unk " type ="text"/><br/>

   <label for ="Mother’s residence ZIP code: 9 ❑ Unk ">7. Mother’s residence ZIP code: 9 ❑ Unk :</label>

    <input id ="Mother’s residence ZIP code: 9 ❑ Unk " name ="Mother’s residence ZIP code: 9 ❑ Unk " type ="text"/><br/>

    <p>8.Mother’s date of birth:</p>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    9. Mother’s obstetric history:

   <label for ="G ">G :</label>

    <input id ="G" name ="G " type ="text"/>

<label for ="P ">P :</label>

    <input id ="P " name ="P " type ="text"/><br/>

    <p>(G=pregnancies, P=live births) </p><br/>

    <p>10. Last menstrual period (LMP) (before delivery):</p>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>11. a) Indicate date of first prenatal visit:</p>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>❑ No prenatal care (Go to Q12)</p>

   <label>b) Indicate trimester of first prenatal visit:</label><br/>

    <input type ="radio" name =" Indicate trimester of first prenatal visit" value ="❑ 1st trimester" id ="❑ 1st trimester">

    <label for ="❑ 1st trimester">❑ 1st trimester</label>

    <input type ="radio" name =" Indicate trimester of first prenatal visit" value ="❑ 2nd trimester " id ="❑ 2nd trimester ">

    <label for ="❑ 2nd trimester ">❑ 2nd trimester </label>

    <input type ="radio" name =" Indicate trimester of first prenatal visit" value ="❑ 3rd trimester" id ="❑ 3rd trimester">

    <label for ="❑ 3rd trimester">❑ 3rd trimester</label>

    <input type ="radio" name =" Indicate trimester of first prenatal visit" value =" 9 ❑ Unk " id =" 9 ❑ Unk ">

    <label for =" 9 ❑ Unk "> 9 ❑ Unk </label><br/>

    <label>12. Mother’s ethnicity:</label>

    <input type ="radio" name ="Mother’s ethnicity" value ="1 ❑ Hispanic or Latino" id ="1 ❑ Hispanic or Latino">

    <label for ="1 ❑ Hispanic or Latino">1 ❑ Hispanic or Latino</label>

    <input type ="radio" name ="Mother’s ethnicity" value ="2 ❑ Non-Hispanic or Latino" id ="2 ❑ Non-Hispanic or Latino">

    <label for ="2 ❑ Non-Hispanic or Latino">2 ❑ Non-Hispanic or Latino</label>

    <input type ="radio" name ="Mother’s ethnicity" value ="9 ❑ Unk " id ="9 ❑ Unk ">

    <label for ="9 ❑ Unk ">9 ❑ Unk </label><br/>

    <label>13.Mother's Race:</label><br/>

    <input type ="radio" name =">Mother's Race" value ="American Indian/Alaskan Native" id ="American Indian/Alaskan Native">

    <label for ="American Indian/Alaskan Native">American Indian/Alaskan Native</label>

    <input type ="radio" name =">Mother's Race" value ="Native Hawaiian/Pacific Islander" id ="Native Hawaiian/Pacific Islander">

    <label for ="Native Hawaiian/Pacific Islander">Native Hawaiian/Pacific Islander</label>

    <input type ="radio" name =">Mother's Race" value ="Asian" id ="Asian">

    <label for ="Asian">Asian</label>

    <input type ="radio" name =">Mother's Race" value ="White" id ="White">

    <label for ="White">White</label>

    <input type ="radio" name =">Mother's Race" value ="Black/African Am." id ="Black/African Am.">

    <label for ="Black/African Am.">Black/African Am.</label>

    <input type ="radio" name =">Mother's Race" value ="Unk" id ="Unk">

    <label for ="Unk">Unk</label>

    <input type ="radio" name =">Mother's Race" value ="Other" id ="Other">

    <label for ="Other">Other</label><br/>

    <p>14. Did mother have non-treponemal or treponemal tests at:</p>

    <p> a) first prenatal visit? b) 28–32 weeks gestation? c) delivery?</p>

    <input type ="radio" name =" Did mother have non-treponemal or treponemal tests at" value ="1 ❑ Yes 2" id ="1 ❑ Yes 2">

    <label for ="1 ❑ Yes 2">1 ❑ Yes 2</label>

    <input type ="radio" name =" Did mother have non-treponemal or treponemal tests at" value ="❑ No 9 " id ="❑ No 9 ">

    <label for ="❑ No 9 ">❑ No 9 </label>

    <input type ="radio" name =" Did mother have non-treponemal or treponemal tests at" value ="❑ Unk 1" id ="❑ Unk 1">

    <label for ="❑ Unk 1">❑ Unk 1</label>

    <input type ="radio" name ="Did mother have non-treponemal or treponemal tests at" value ="❑ Yes 2" id ="❑ Yes 2">

    <label for ="❑ Yes 2">❑ Yes 2</label>

    <input type ="radio" name ="Did mother have non-treponemal or treponemal tests at" value ="❑ Yes 2" id ="❑ Yes 2">

    <label for ="❑ Yes 2">❑ Yes 2</label>

    <input type ="radio" name ="Did mother have non-treponemal or treponemal tests at" value ="❑ Unk " id ="❑ Unk ">

    <label for ="❑ Unk">❑ Unk"</label><br/>

    <label>15. Mother’s marital status:</label><br/>

    <input type ="radio" name ="Mother’s marital status" value ="1 ❑ Single, never married " id ="1 ❑ Single, never married ">

    <label for ="1 ❑ Single, never married">1 ❑ Single, never married</label><br/>

    <input type ="radio" name ="Mother’s marital status" value ="2 ❑ Married" id ="2 ❑ Married ">

    <label for ="2 ❑ Married">2 ❑ Married"</label><br/>

    <input type ="radio" name ="Mother’s marital status" value ="3 ❑ Separated/Divorced" id ="3 ❑ Separated/Divorced">

    <label for ="3 ❑ Separated/Divorced">3 ❑ Separated/Divorced</label>

    <p> 16. Indicate during pregnancy and delivery, dates and results of a) most recent and b) first non-treponemal tests:</p>

    <p>DATE</p><br/>

    <label for ="date">a. Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label for ="date">b. Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <input type ="radio" name ="pregnancy and delivery" value ="9 ❑ Unk" id ="9 ❑ Unk">

    <label for ="9 ❑ Unk">9 ❑ Unk</label>

    <input type ="radio" name ="pregnancy and delivery" value ="9 ❑ Unk " id ="9 ❑ Unk">

    <label for ="9 ❑ Unk">9 ❑ Unk</label>

    <p> Results </p>

    <input type ="radio" name="Results " value =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk"  id =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk ">

    <label for =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk "> 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk </label>

    <input type ="radio" name ="Results  " value =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk " id =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk  ">

    <label for =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk "> 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk </label>

    <p>Titer </p>

    <input type ="radio" name ="Titer   " value ="1 " id ="1" >

    <label for ="1">1:</label><br/>

    <input type ="radio" name ="Titer   " value ="1" id ="1 ">

    <label for ="1">1:</label><br/>

    <p>17. Indicate during pregnancy, date, type, and result of a) first and b) most recent treponemal tests:</p><br/>

    <p>Date</p><br/>

    <label for ="date">Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label for ="date">Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>Test Type </p>

    <input type ="radio" name ="Test Type " value =" 1 ❑ EIA or CLIA 3 ❑ Other  " id =" 1 ❑ EIA or CLIA 3 ❑ Other  ">

    <label for =" 1 ❑ EIA or CLIA 3 ❑ Other "> 1 ❑ EIA or CLIA 3 ❑ Other </label><br/>

    <input type ="radio" name ="Test Type" value ="2 ❑ TP-PA 9 ❑ Unk " id ="2 ❑ TP-PA 9 ❑ Unk ">

    <label for ="2 ❑ TP-PA 9 ❑ Unk">2 ❑ TP-PA 9 ❑ Unk</label><br/>

    <input type ="radio" name ="Test Type" value ="1 ❑ EIA or CLIA 3 ❑ Other" id ="1 ❑ EIA or CLIA 3 ❑ Other">

    <label for ="1 ❑ EIA or CLIA 3 ❑ Other">1 ❑ EIA or CLIA 3 ❑ Other</label><br/>

    <input type ="radio" name ="Test Type" value =" 2 ❑ TP-PA 9 ❑ Unk " id =" 2 ❑ TP-PA 9 ❑ Unk ">

    <label for =" 2 ❑ TP-PA 9 ❑ Unk"> 2 ❑ TP-PA 9 ❑ Unk</label><br/>

    <p>Results</p>

    <input type ="radio" name ="Results  " value =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk  " id =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk  ">

    <label for =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk "> 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk </label><br/>

    <input type ="radio" name ="Results  " value =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk  " id =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk ">

    <label for =" 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk "> 1 ❑ Reactive 2 ❑ Nonreactive 9 ❑ Unk </label><br/>

    <p>18. What was mother’s HIV status during pregnancy?</p><br/>

    <input type ="radio" name =" HIV status  " value =" P ❑ positive " id =" P ❑ positive ">

    <label for =" P ❑ positive"> P ❑ positive</label>

    <input type ="radio" name =" HIV status  " value ="X ❑ patient not tested " id ="X ❑ patient not tested ">

    <label for ="X ❑ patient not tested">X ❑ patient not tested</label>

    <input type ="radio" name ="HIV status   " value ="E ❑ equivocal test" id ="E ❑ equivocal test ">

    <label for ="E ❑ equivocal test">E ❑ equivocal test</label>

    <input type ="radio" name =" HIV status  " value ="N ❑ negative " id ="N ❑ negative ">

    <label for ="N ❑ negative">N ❑ negative</label>

    <input type ="radio" name ="HIV status   " value ="U ❑ Unk " id ="U ❑ Unk ">

    <label for ="U ❑ Unk">U ❑ Unk</label><br/>

    <label>19 What CLINICAL stage of syphilis did mother have during  pregnancy?</label><br/>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value =" ❑ primary " id =" ❑ primary ">

    <label for =" ❑ primary">1 ❑ primary</label>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value ="❑ secondary " id ="❑ secondary ">

    <label for =">❑ secondary>❑2.secondary</label>

    <input type ="radio" name ="CLINICAL stage of syphilis" value =" ❑ early latent " id ="❑ early latent ">

    <label for =" ❑ early latent">3 ❑ early latent</label>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value ="4 late or late latent " id =" ❑ late or late latent ">

    <label for ="4 ❑ late or late latent">4 ❑ late or late latent</label>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value =" ❑ previously treated/serofast " id =" ❑ previously treated/serofast ">

    <label for ="❑ previously treated/serofast">5 ❑ previously treated/serofast</label>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value ="8 ❑ Other  " id =" Other  ">

    <label for ="8 ❑ Other ">8 ❑ Other </label>

    <input type ="radio" name ="CLINICAL stage of syphilis  " value ="9 ❑ Unk " id =" 9 ❑ Unk ">

    <label for ="9 ❑ Unk"> 9 ❑ Unk</label><br/>

    <label>20. What SURVEILLANCE stage of syphilis did mother have during pregnancy?</label><br/>

    <label for =" ❑ primary">1 ❑ primary</label><br/>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="❑ secondary " id ="❑ secondary ">

    <label for =">❑ secondary>❑2.secondary</label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis" value =" ❑ early latent " id ="❑ early latent ">

    <label for =" ❑ early latent">3 ❑ early latent</label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="4 late or late latent " id =" ❑ late or late latent ">

    <label for ="4 ❑ late or late latent">4 ❑ late or late latent</label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value =" ❑ previously treated/serofast " id =" ❑ previously treated/serofast ">

    <label for ="❑ previously treated/serofast">5 ❑ previously treated/serofast</label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="8 ❑ Other  " id =" Other  ">

    <label for ="8 ❑ Other ">8 ❑ Other </label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="❑ Unk " id ="❑ Unk ">

    <label for ="❑ Unk"></label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="9 ❑ Unk " id =" 9 ❑ Unk ">

    <label for ="9 ❑ Unk"> 9 ❑ Unk</label>

    <input type ="radio" name =" SURVEILLANCE stage of syphilis  " value ="❑ Unk " id ="❑ Unk ">

    <label for ="❑ Unk"></label>

    <p>21. When did mother receive her first dose of benzathine penicillin?</p>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    22. <label>What was mother’s treatment?<br/>

    <input type ="radio" name =" mother’s treatment?  " value ="1 ❑ 2.4 M units benzathine penicillin   " id ="1 ❑ 2.4 M units benzathine penicillin ">

    <label for ="1 ❑ 2.4 M units benzathine penicillin  ">8 ❑ 1 ❑ 2.4 M units benzathine penicillin</label>

    <input type ="radio" name =" mother’s treatment?  " value =" 2 ❑ 4.8 M units benzathine penicillin   " id ="  2 ❑ 4.8 M units benzathine penicillin  ">

    <label for =" 2 ❑ 4.8 M units benzathine penicillin  "> 2 ❑ 4.8 M units benzathine penicillin </label>

    <input type ="radio" name =" mother’s treatment?  " value =" 3 ❑ 7.2 M units benzathine penicillin  " id =" 3 ❑ 7.2 M units benzathine penicillin  ">

    <label for =" 3 ❑ 7.2 M units benzathine penicillin  "> </label>

    <input type ="radio" name =" mother’s treatment?  " value ="8 ❑ Other 9 ❑ Unk  " id =" 8 ❑ Other 9 ❑ Unk  ">

    <label for ="8 ❑ Other 9 ❑ Unk ">8 ❑ Other 9 ❑ Unk </label><br/>

    <label>23. Did mother have an appropriate serologic response?</label><br/>

    <input type ="radio" name =" serologic response  " value =" 1 ❑ Yes, appropriate response   " id ="  1 ❑ Yes, appropriate response  ">

    <label for =" 1 ❑ Yes, appropriate response  "> 1 ❑ Yes, appropriate response  </label>

    <input type ="radio" name =" serologic response  "  2 ❑ No, inappropriate response: evidence of treatment failure or reinfection" id =" 2 ❑ No, inappropriate response: evidence of treatment failure or reinfection ">

    <label for =" 2 ❑ No, inappropriate response: evidence of treatment failure or reinfection  ">2 ❑ No, inappropriate response: evidence of treatment failure or reinfection </label>

    <input type ="radio" name =" serologic response  " value =" 3 ❑ Response could not be determined from available non-treponemal

    titer information   " id ="  3 ❑ Response could not be determined from available non-treponemal

    titer information   ">

    <label for =" 3 ❑ Response could not be determined from available non-treponemal

    titer information "> 3 ❑ Response could not be determined from available non-treponemal

    titer information </label>

    <h2>Part II. Infant/ChIld InforMatIon<h2>

    <label for ="date"> 24. Date of Delivery: 9 ❑ Unk </label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>25. Vital status:</label>

    <input type ="radio" name ="Vital status  " value ="1 ❑ Alive (Go to Q27)  " id ="1 ❑ Alive (Go to Q27)  ">

    <label for ="1 ❑ Alive (Go to Q27) ">1 ❑ Alive (Go to Q27) </label>

    <input type ="radio" name =" Vital status  " value =" 2 ❑ Born alive, then died " id =" 2 ❑ Born alive, then died  ">

    <label for =" 2 ❑ Born alive, then died "> 2 ❑ Born alive, then died </label>

    <input type ="radio" name =" Vital status  " value ="3 ❑ Stillborn (Go to Q27) (Footnote C)  " id =" 3 ❑ Stillborn (Go to Q27) (Footnote C)  ">

    <label for ="3 ❑ Stillborn (Go to Q27) (Footnote C) ">3 ❑ Stillborn (Go to Q27) (Footnote C) </label>

    <input type ="radio" name =" Vital status " value ="9 ❑ Unknown (Go to Q27)   " id =" 9 ❑ Unknown (Go to Q27)   ">

    <label for ="9 ❑ Unknown (Go to Q27)  ">9 ❑ Unknown (Go to Q27)  </label><br/>

    <label for ="date"> 26. Indicate date of death: 9 ❑ Unk  </label><br/>

    <input type ="date" name ="date" id ="date"/><br/>

    <label for ="Birthweight (in grams): 9 ❑ Unk  ">27. Birthweight (in grams): 9 ❑ Unk  :</label>

    <input id ="Birthweight (in grams): 9 ❑ Unk  " name ="Birthweight (in grams): 9 ❑ Unk  " type ="text"/><br/>

    <label for ="Estimated gestational age (in weeks): 99 ❑ Unk  ">28. Estimated gestational age (in weeks): 99 ❑ Unk</label>

    <input id ="Estimated gestational age (in weeks): 99 ❑ Unk  " name ="Estimated gestational age (in weeks): 99 ❑ Unk  " type ="text"/><br/>

    <p>(If infant was stillborn go to Q37) </p>

    <label>29. a) Did infant/ child have a reactive non-treponemal test for syphilis? (eg., VDRL, RPR)</label>

    <input type ="radio" name ="reactive non-treponemal test  " value ="1 ❑ Yes  " id ="1 ❑ Yes  ">

    <label for ="1 ❑ Yes ">1 ❑ Yes </label>

    <input type ="radio" name ="reactive non-treponemal test  " value ="2 ❑ No  " id ="2 ❑ No  ">

    <label for ="2 ❑ No ">2 ❑ No </label>

    <input type ="radio" name ="reactive non-treponemal test  " value ="3 ❑ No test  " id =" 3 ❑ No test ">

    <label for ="3 ❑ No test ">3 ❑ No test</label>

    <input type ="radio" name ="reactive non-treponemal test  " value ="9 ❑ Unk  " id ="9 ❑ Unk  ">

    <label for ="9 ❑ Unk ">9 ❑ Unk </label>

    <p>(Go to Q30 unless reactive) </p><br/>

    <label for ="date"> B.When was the infant/child’s first reactive non-treponemal test for syphilis?</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>c) Indicate titer of infant/ child’s non-treponemal test for syphilis: </label>

    <input type ="radio" name ="infant/ child’s non-treponemal  " value ="1:  " id ="1:  ">

    <label for ="1: ">1: </label><br/>

    <label>30. a) Did infant/child have a reactive treponemal test for syphilis? (footnote D) </label><br/>

    <input type ="radio" name ="reactive treponemal test  " value ="1 ❑ Yes  " id ="1 ❑ Yes  ">

    <label for ="1 ❑ Yes ">1 ❑ Yes </label>

    <input type ="radio" name ="reactive treponemal test  " value ="2 ❑ No  " id ="2 ❑ No  ">

    <label for ="2 ❑ No ">2 ❑ No </label>

    <input type ="radio" name ="reactive treponemal test  " value ="No 3 ❑ No  " id ="No 3 ❑ No  ">

    <label for ="No 3 ❑ No ">No 3 ❑ No </label>

    <input type ="radio" name ="reactive treponemal test  " value ="9 ❑ Unk   " id ="9 ❑ Unk   ">

    <label for ="9 ❑ Unk  ">9 ❑ Unk  </label>

    <label for ="date"> b) When was the infant/child’s first reactive treponemal test for syphilis? (footnote D)</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>31. Did the infant/child, placenta, or cord have darkfield exam, DFA, or special stains? </label>

    <input type ="radio" name ="infant/child, placenta, or cord have darkfield exam, DFA, or special stains  " value ="positive 1 ❑ Yes, " id ="positive 1 ❑ Yes,  ">

    <label for ="positive 1 ❑ Yes, ">positive 1 ❑ Yes, </label>

    <input type ="radio" name ="infant/child, placenta, or cord have darkfield exam, DFA, or special stains  " value ="2 ❑ Yes, negative " id ="2 ❑ Yes, negative ">

    <label for ="2 ❑ Yes, negative ">2 ❑ Yes, negative </label>

    <input type ="radio" name ="infant/child, placenta, or cord have darkfield exam, DFA, or special stains  " value ="3 ❑ No test " id ="3 ❑ No test ">

    <label for ="3 ❑ No test ">3 ❑ No test </label>

    <input type ="radio" name ="infant/child, placenta, or cord have darkfield exam, DFA, or special stains  " value ="4 ❑ No lesions and no tissue to test" id ="4 ❑ No lesions and no tissue to test ">

    <label for ="4 ❑ No lesions and no tissue to test ">4 ❑ No lesions and no tissue to test </label>

    <input type ="radio" name ="infant/child, placenta, or cord have darkfield exam, DFA, or special stains  " value ="9 ❑ Unk  " id ="9 ❑ Unk ">

    <label for ="9 ❑ Unk ">9 ❑ Unk </label><br/>

    <label>32. Did the Infant/child have any signs of CS? (check all that apply)</label><br/>

    <input type ="radio" name ="Infant/child have any signs of CS? " value ="❑ no signs/asymptomatic (Footnote E)  " id ="❑ no signs/asymptomatic (Footnote E)">

    <label for ="❑ no signs/asymptomatic (Footnote E) ">❑ no signs/asymptomatic (Footnote E) </label>

    <input type ="radio" name ="Infant/child have any signs of CS?  " value ="❑ condyloma lata ❑ snuffles ❑ syphilitic skin rash " id ="❑ condyloma lata ❑ snuffles ❑ syphilitic skin rash  ">

    <label for ="❑ condyloma lata ❑ snuffles ❑ syphilitic skin rash ">❑ condyloma lata ❑ snuffles ❑ syphilitic skin rash </label>

    <input type ="radio" name ="Infant/child have any signs of CS?  " value ="❑ hepatosplenomegaly  " id ="❑ hepatosplenomegaly  ">

    <label for ="❑ hepatosplenomegaly ">❑ hepatosplenomegaly </label>

    <input type ="radio" name ="Infant/child have any signs of CS?  " value ="❑ jaundice/hepatitis  " id ="❑ jaundice/hepatitis  ">

    <label for ="❑ jaundice/hepatitis ">❑ jaundice/hepatitis </label>

    <input type ="radio" name ="Infant/child have any signs of CS?  " value ="❑ pseudo paralysis  " id ="❑ pseudo paralysis">

    <label for ="❑ pseudo paralysis ">❑ pseudo paralysis </label>

    <input type ="radio" name ="Infant/child have any signs of CS?  " value ="❑ edema  " id ="❑ edema  ">

    <label for ="❑ edema ">❑ edema </label>

    <input type ="radio" name ="Infant/child have any signs of CS?" value ="❑ other  " id ="❑ other ">

    <label for ="❑ other ">❑ other </label>

    <input type ="radio" name ="Infant/child have any signs of CS?" value ="❑ Unk   " id ="❑ Unk  ">

    <label for ="❑ Unk  ">❑ Unk  </label><br/>

    <label>33. Did the infant/child have long bone X-rays?</label><br/>

    <input type ="radio" name ="infant/child have long bone X-rays?" value ="1 ❑ Yes, changes consistent with CS  " id ="1 ❑ Yes, changes consistent with CS  ">

    <label for ="1 ❑ Yes, changes consistent with CS ">1 ❑ Yes, changes consistent with CS</label>

    <input type ="radio" name ="infant/child have long bone X-rays?" value ="2 ❑ Yes, no signs of CS  " id ="2 ❑ Yes, no signs of CS  ">

    <label for ="2 ❑ Yes, no signs of CS ">2 ❑ Yes, no signs of CS </label>

    <input type ="radio" name ="infant/child have long bone X-rays?" value ="3 ❑ No X-rays  " id ="3 ❑ No X-rays  ">

    <label for ="3 ❑ No X-rays ">3 ❑ No X-rays </label>

    <input type ="radio" name ="infant/child have long bone X-rays?" value ="9 ❑ Unk   " id ="9 ❑ Unk   ">

    <label for ="9 ❑ Unk  ">9 ❑ Unk  </label><br/>

    <label>34. Did the infant/child have a CSF-VDRL?</label>

    <input type ="radio" name ="infant/child have a CSF-VDRL?" value ="1 ❑ Yes, reactive  " id ="1 ❑ Yes, reactive  ">

    <label for ="1 ❑ Yes, reactive ">1 ❑ Yes, reactive </label>

    <input type ="radio" name ="infant/child have a CSF-VDRL?" value ="2 ❑ Yes, nonreactive  " id ="2 ❑ Yes, nonreactive  ">

    <label for ="2 ❑ Yes, nonreactive ">2 ❑ Yes, nonreactive </label>

    <input type ="radio" name ="infant/child have a CSF-VDRL?" value ="3 ❑ No test   " id ="3 ❑ No test   ">

    <label for ="3 ❑ No test  ">3 ❑ 3 ❑ No test  </label>

    <input type ="radio" name ="infant/child have a CSF-VDRL?" value ="9 ❑ Unk    " id ="9 ❑ Unk    ">

    <label for ="9 ❑ Unk">9 ❑ Unk   </label>

    <label>35. Did the infant/child have a CSF WBC count or CSF protein test? (Footnote F)</label><br/>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="1 ❑ Yes, CSF WBC count elevated  " id ="1 ❑ Yes, CSF WBC count elevated ">

    <label for ="1 ❑ Yes, CSF WBC count elevated ">1 ❑ Yes, CSF WBC count elevated  </label>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="2 ❑ Yes, CSF protein elevated"   id ="2 ❑ Yes, CSF protein elevated ">

    <label for ="2 ❑ Yes, CSF protein elevated ">2 ❑ Yes, CSF protein elevated</label>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="3 ❑ both tests elevated  " id ="3 ❑ both tests elevated">

    <label for ="3 ❑ both tests elevated ">3 ❑ both tests elevated </label>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="4 ❑ neither test elevated  " id ="4 ❑ neither test elevated">

    <label for ="4 ❑ neither test elevated">4 ❑ neither test elevated </label>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="5 ❑ No test  " id ="5 ❑ No test  ">

    <label for ="5 ❑ No test ">5 ❑ No test </label>

    <input type ="radio" name ="infant/child have a CSF WBC count or CSF protein test" value ="9 ❑ Unk   " id ="9 ❑ Unk   ">

    <label for ="9 ❑ Unk  ">9 ❑ Unk  </label><br/>

    <label> 36. Was the infant/child treated? (“2” is an obsolete response)</label><br/>

    <input type ="radio" name ="infant/child treated?" value ="1 ❑ Yes, with aqueous or procaine penicillin for 10 days  " id ="1 ❑ Yes, with aqueous or procaine penicillin for 10 days  ">

    <label for ="1 ❑ Yes, with aqueous or procaine penicillin for 10 days ">1 ❑ Yes, with aqueous or procaine penicillin for 10 days </label>

    <input type ="radio" name ="infant/child treated?" value ="3 ❑ Yes, with benzathine penicillin x 1  " id ="3 ❑ Yes, with benzathine penicillin x 1  ">

    <label for ="3 ❑ Yes, with benzathine penicillin x 1 ">3 ❑ Yes, with benzathine penicillin x 1</label>

    <input type ="radio" name ="infant/child treated?" value ="4 ❑ Yes, with other treatment  " id ="4 ❑ Yes, with other treatment  ">

    <label for ="4 ❑ Yes, with other treatment ">4 ❑ Yes, with other treatment </label>

    <input type ="radio" name ="infant/child treated?" value ="5 ❑ No treatment  " id ="5 ❑ No treatment ">

    <label for ="5 ❑ No treatment ">5 ❑ No treatment </label>

    <input type ="radio" name ="infant/child treated?" value ="9 ❑ Unk   " id ="9 ❑ Unk   ">

    <label for ="9 ❑ Unk  ">9 ❑ Unk  </label><br/>

    <h3>Part III. CongenItal SyPhIlIS CaSe ClaSSIfICatIon</h3>

    <label>37. Classification:</label><br/>

    <input type ="radio" name ="Classification" value ="1 ❑ Not a case " id ="1 ❑ Not a case  ">

    <label for ="1 ❑ Not a case ">1 ❑ Not a case </label>

    <input type ="radio" name =" Classification ">  value="2 ❑ Confirmed case (Laborator y confirmed identification of T.pallidum, e.g., darkfield exam, DFA, or special stains) "      id ="2 ❑ Confirmed case (Laborator y confirmed identification of T.pallidum, e.g., darkfield exam, DFA, or special stains)  ">

    <label for ="2 ❑ Confirmed case (Laborator y confirmed identification of T.pallidum, e.g., darkfield exam, DFA, or special stains)  ">2 ❑ Confirmed case (Laborator y confirmed identification of T.pallidum, e.g., darkfield exam, DFA, or special stains)  </label>

    <input type ="radio" name ="Classification" value ="3 ❑ Syphilitic stillbirth(Footnote C )   " id ="3 ❑ Syphilitic stillbirth(Footnote C )   ">

    <label for =""3 ❑ Syphilitic stillbirth(Footnote C )"> "3 ❑ Syphilitic stillbirth(Footnote C )</label>

    <input type ="radio" name ="Classification" value ="4 ❑ Probable case (A case identified by the algorithm, which is not a confirmed case or syphilitic stillbir th)  " id ="4 ❑ Probable case (A case identified by the algorithm, which is not a confirmed case or syphilitic stillbir th)  ">

    <label for ="4 ❑ Probable case (A case identified by the algorithm, which is not a confirmed case or syphilitic stillbir th) ">4 ❑ Probable case (A case identified by the algorithm, which is not a confirmed case or syphilitic stillbir th) </label>

    </form>

    </body>

    </html>

e. Form 5 / Navigation 5 = Chlamydia & Gonorrhea case reporting form

<!DOCTYPE html>

<html>

<head>

<meta charset="utf-8">

<meta name ="keywords" content ="HTML 5, CSS 3, JavaScript, jquery, Angularjs"/>

<meta name ="description" content ="Dynamic web development">

<meta name = "author" content ="lawrence">

<meta name = "viewport" content ="width=device-width,initial-scale=1.0">

<title>REGISTRATION FORM</title>

<link rel ="stylesheet" href ="font-awesome/css/font-awesome.min.css">

<link rel ="stylesheet" type ="text/css" href ="../css/main.css">

</head>

<body>

    <h1>Reporting Form for Chlamydia and Gonorrhea</h1>

    <h2>Clinic Information</h2>

<form>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/>

    <label for ="Person Completing Form">Person Completing Form:</label>

    <input id ="Person Completing Form" name ="Person Completing Form" type ="text"/><br/>

    <label for ="Health Provider">Health Provider:</label>

    <input id ="Health Provider" name ="Health Provider" type ="text"/>

    <label for ="tel">Contact phone number/fax:</label>

    <input type = "tel" name ="tel" id ="tel"/><br/>

    <h3>Patient Information — Please complete all information requested below</h3>

    <label for ="name">1.Name:</label>

    <input id ="name" name ="name" type ="text"/>

    <label for ="dob">Date of Birth:</label>

    <input type ="date" id ="dob" name ="dob">

    <label>gender:</label>

    <input type ="radio" name ="Gender" value ="female" id ="Female">

    <label for ="Female">Female</label>

    <input type ="radio" name ="Gender" value ="Male" id ="Male">

    <label for ="Male">Male</label>

    <input type ="radio" name ="Gender" value ="other" id ="other">

    <label for ="other">other</label><br/>

    <label for ="address">2.Address:</label>

    <input id ="address" name ="address" type ="text"/>

    <label for ="street city/state zip">street city/state zip:</label>

    <input id ="street city/state zip" name ="street city/state zip" type ="text"/><br/>

    <label for ="tel">phone number:</label>

    <input type = "tel" name ="tel" id ="tel"/>

    <label for ="ALTERNATIVE #"> ALTERNATIVE #:</label>

    <input id ="ALTERNATIVE #" name ="ALTERNATIVE #" type ="text"/><br/>

    <label>3.PREGNANCY TEST RESULTS:</label><br/>

    <input type ="radio" name ="PREGNANCY TEST RESULTS" value ="N/A" id ="N/A">

    <label for ="N/A">N/A</label>

    <input type ="radio" name ="PREGNANCY TEST RESULTS" value =" Negative" id =" Negative">

    <label for =" Negative"> Negative</label>

    <input type ="radio" name ="PREGNANCY TEST RESULTS" value ="Unknown" id ="Unknown">

    <label for ="Unknown">Unknown</label>

    <input type ="radio" name ="PREGNANCY TEST RESULTS" value ="Positive: If positive how many weeks?" id ="Positive: If positive how many weeks?">

    <label for ="Positive: If positive how many weeks?">Positive: If positive how many weeks?</label><br/>

    <label>4.ETHNICITY:</label><br/>

    <input type ="radio" name ="ETHNICITY" value ="Hispanic" id ="Hispanic">

    <label for =" Hispanic"> Hispanic</label>

    <input type ="radio" name ="ETHNICITY" value ="Non-Hispanic" id ="Non-Hispanic">

    <label for ="Non-Hispanic">Non-Hispanic</label>

    <input type ="radio" name ="ETHNICITY" value ="Unknown" id ="Unknown">

    <label for ="Unknown">Unknown</label><br/>

    <label>Race:</label><br/>

    <input type ="radio" name ="race" value ="American Indian/Alaskan Native" id ="American Indian/Alaskan Native">

    <label for ="American Indian/Alaskan Native">American Indian/Alaskan Native</label>

    <input type ="radio" name ="race" value ="Native Hawaiian/Pacific Islander" id ="Native Hawaiian/Pacific Islander">

    <label for ="Native Hawaiian/Pacific Islander">Native Hawaiian/Pacific Islander</label>

    <input type ="radio" name ="race" value ="Asian" id ="Asian">

    <label for ="Asian">Asian</label>

    <input type ="radio" name ="race" value ="White" id ="White">

    <label for ="White">White</label>

    <input type ="radio" name ="race" value ="Black/African Am." id ="Black/African Am.">

    <label for ="Black/African Am.">Black/African Am.</label>

    <input type ="radio" name ="race" value ="Unk" id ="Unk">

    <label for ="Unk">Unk</label>

    <input type ="radio" name ="race" value ="Other" id ="Other">

    <label for ="Other">Other</label><br/>

    <label>Gender for sex partner </label>

    <input type ="radio" name ="Gender for sex partner " value ="male" id ="male">

    <label for ="male">male</label><br/>

    <input type ="radio" name ="Gender for sex partner " value ="female" id ="female">

    <label for ="female">female</label><br/>

    <input type ="radio" name ="Gender for sex partner " value =" Both" id =" Both">

    <label for =" Both">Both</label><br/>

    <input type ="radio" name ="Gender for sex partner " value ="unknown" id ="unknown">

    <label for ="unknown">unknown</label><br/>

    <label>5.TEST RESULT TYPE:</label><br/>

    <input type ="radio" name ="TEST RESULT TYPE:" value ="Chlamydia Positive Result" id ="Chlamydia Positive Result">

    <label for ="Chlamydia Positive Result">Chlamydia Positive Result</label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/>

    <input type ="radio" name ="TEST RESULT TYPE:" value ="Gonorrhea Positive Result " id ="Gonorrhea Positive Result ">

    <label for ="Gonorrhea Positive Result ">Gonorrhea Positive Result </label>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>PREVIOUS HIV TESTING:</label>

    <input type ="radio" name ="PREVIOUS HIV TESTING" value ="yes " id ="yes ">

    <label for ="yes ">yes </label>

    <input type ="radio" name ="PREVIOUS HIV TESTING" value ="no " id ="no ">

    <label for ="no ">no </label>

    <input type ="radio" name ="PREVIOUS HIV TESTING" value =" Unknown" id =" Unknown ">

    <label for =" Unknown "> Unknown </label><br/>

    <label>If yes, last result was?</label>

    <input type ="radio" name ="If yes, last result was?" value ="pos" id =" pos ">

    <label for =" pos "> pos </label>

    <input type ="radio" name ="If yes, last result was?" value ="NEG" id =" NEG ">

    <label for =" NEG "> NEG </label>

    <input type ="radio" name ="If yes, last result was?" value =" Unknown" id =" Unknown ">

    <label for =" Unknown "> Unknown </label><br/>

    <label for ="month"> month of last test</label>

    <input type ="month" name ="month" id ="month"/>

    <label for ="year"> year of last test</label>

    <input type ="year" name ="year" id ="year"/><br/>

    <label>6 REASON FOR EXAM:</label><br/>

    <input type ="radio" name ="REASON FOR EXAM" value ="Symptomatic" id ="Symptomatic ">

    <label for =" Symptomatic "> Symptomatic </label><br/>

    <input type ="radio" name ="REASON FOR EXAM" value =" Routine Exam " id ="  Routine Exam  ">

    <label for ="  Routine Exam  ">  Routine Exam  </label><br/>

    <input type ="radio" name ="REASON FOR EXAM" value ="Test for Cure" id ="Test for Cure ">

    <label for =" Test for Cure "> Test for Cure </label><br/>

    <input type ="radio" name ="REASON FOR EXAM" value =" Exposed to Infection " id =" Exposed to Infection  ">

    <label for ="  Exposed to Infection  ">  Exposed to Infection  </label><br/>

    <input type ="radio" name ="REASON FOR EXAM" value ="Pregnant" id ="Pregnant ">

    <label for =" Pregnant "> Pregnant </label><br/>

    <label>DIAGNOSIS:</label><br/>

    <input type ="radio" name ="DIAGNOSIS" value ="Asymptomatic" id ="Asymptomatic ">

    <label for =" Asymptomatic "> Asymptomatic </label><br/>

    <input type ="radio" name ="DIAGNOSIS" value ="Symptomatic-Uncomplicated " id ="Symptomatic-Uncomplicated  ">

    <label for =" Symptomatic-Uncomplicated  "> Symptomatic-Uncomplicated  </label><br/>

    <input type ="radio" name ="DIAGNOSIS" value ="Pelvic Inflammatory Disease (PID) " id ="Pelvic Inflammatory Disease (PID)  ">

    <label for =" Pelvic Inflammatory Disease (PID)  "> Pelvic Inflammatory Disease (PID)  </label><br/>

    <input type ="radio" name ="DIAGNOSIS" value ="Ophthalmia /conjunctivitis" id ="Ophthalmia /conjunctivitis ">

    <label for =" Ophthalmia /conjunctivitis "> Ophthalmia /conjunctivitis </label><br/>

    <input type ="radio" name ="DIAGNOSIS" value ="Disseminated" id ="Disseminated ">

    <label for =" Disseminated "> Disseminated </label><br/>

    <label>SITE(S):</label><br/>

    <input type ="radio" name ="SITE(S)" value ="Cervix" id ="Cervix">

    <label for ="Cervix"> Cervix </label><br/>

    <input type ="radio" name ="SITE(S)" value =" Vaginal" id =" Vaginal ">

    <label for ="  Vaginal ">  Vaginal </label><br/>

    <input type ="radio" name ="SITE(S)" value ="Urethra" id ="Urethra ">

    <label for =" Urethra "> Urethra </label><br/>

    <input type ="radio" name ="SITE(S)" value ="Symptomatic" id ="Symptomatic ">

    <label for =" Symptomatic "> Rectum </label><br/>

    <input type ="radio" name ="SITE(S)" value ="Rectum" id ="Rectum ">

    <label for =" Rectum "> Rectum </label><br/>

    <input type ="radio" name ="SITE(S)" value =" Ocular" id =" Ocular">

    <label for =" Ocular">  Ocular </label><br/>

    <input type ="radio" name ="SITE(S)" value ="Urine" id ="Urine">

    <label for ="Urine"> Urine </label><br/>

    <input type ="radio" name ="SITE(S)" value ="Pharynx " id ="Pharynx ">

    <label for ="Pharynx "> Pharynx  </label><br/>

    <input type ="radio" name ="SITE(S)" value ="other" id ="other">

    <label for ="other"> other </label><br/>

    <label>7.GONORRHEA TREATMENT PLAN:</label><br/>

    <input type ="radio" name ="GONORRHEA TREATMENT PLAN:" value ="Rocephin/Ceftriaxone 250mg IM x 1." id ="Rocephin/Ceftriaxone 250mg IM x 1.">

    <label for ="Rocephin/Ceftriaxone 250mg IM x 1."> Rocephin/Ceftriaxone 250mg IM x 1. </label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>PLUS</p><br/>

    <input type ="radio" name ="GONORRHEA TREATMENT PLAN" value ="Azithromycin 1gm orally in a single dose." id ="Azithromycin 1gm orally in a single dose.">

    <label for ="Azithromycin 1gm orally in a single dose."> Azithromycin 1gm orally in a single dose. </label><br/>

    <input type ="radio" name ="GONORRHEA TREATMENT PLAN" value ="Azithromycin 1gm orally in a single dose." id ="Azithromycin 1gm orally in a single dose.">

    <label for ="Azithromycin 1gm orally in a single dose."> Azithromycin 1gm orally in a single dose.</label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>CHLAMYDIA TREATMENT PLAN:</label><br/>

    <p>OR</p><br/>

    <input type ="radio" name ="CHLAMYDIA TREATMENT PLAN" value ="Doxycycline 100mg BID x 7 days." id ="Doxycycline 100mg BID x 7 days.">

    <label for ="Doxycycline 100mg BID x 7 days."> Doxycycline 100mg BID x 7 days. </label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>(contraindicated during pregnancy)</p>

    <label>Alternative Treatment Regimens Alternative Treatment Regimens</label>

    <input type ="radio" name ="Alternative Treatment Regimens Alternative Treatment Regimens" value ="Cefixime 400mg orally in a single dose" id ="Cefixime 400mg orally in a single dose">

    <label for ="Cefixime 400mg orally in a single dose"> Cefixime 400mg orally in a single dose </label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label>plus</label>

    <input type ="radio" name ="plus" value =" Azithromycin 1 gm orally in a single dose" id =" Azithromycin 1 gm orally in a single dose">

    <label for =" Azithromycin 1 gm orally in a single dose">  Azithromycin 1 gm orally in a single dose </label><br/>

    <input type ="radio" name ="plus" value =" Amoxicillin 500mg orally tid X 7 days" id =" Amoxicillin 500mg orally tid X 7 days">

    <label for =" Amoxicillin 500mg orally tid X 7 days"> Amoxicillin 500mg orally tid X 7 days</label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <input type ="radio" name ="Other Treatment" value ="Other Treatment" id ="Other Treatment">

    <label for ="Other Treatment"> Other Treatment </label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <p>(test of cure recommended at 1 month)</p>

    <input type ="radio" name ="Other Treatment" value ="Other Treatment" id ="Other Treatment">

    <label for ="Other Treatment"> Other Treatment </label><br/>

    <label for ="date"> Date</label>

    <input type ="date" name ="date" id ="date"/><br/>

    <label> 8. IF NOT TREATED YET — PATIENT NOTIFIED OF INFECTION:</label>

    <input type ="radio" name ="IF NOT TREATED YET — PATIENT NOTIFIED OF INFECTION:" value ="yes" id ="yes">

    <label for ="yes">yes </label><br/>

    <input type ="radio" name ="IF NOT TREATED YET — PATIENT NOTIFIED OF INFECTION:" value ="NO" id ="no">

    <label for ="no">no </label><br/>

    <p>9. PARTNER MANAGEMENT PLAN — Ensuring Partner Treatment</p>

    <label>Expedited Partner Therapy dispensed at time of visit?</label>

    <input type ="radio" name ="Expedited Partner Therapy dispensed at time of visit?" value ="no" id ="no">

    <label for ="no"> no </label><br/>

    <input type ="radio" name ="Expedited Partner Therapy dispensed at time of visit?" value ="other" id ="other">

    <label for ="yes"> yes </label><br/>

    <label for ="How many partners?">How many partners?:</label>

    <input id ="How many partners?" name ="How many partners?" type ="text"/><br/>

</form>

</body>

</html>

4. Neatness and use of appropriate form elements and responsiveness - (20 marks).

h1{

    color:blue;

}

.topnav ul{

    list-style-type:none;

    margin: 50px;

    float:right;

}

.topnav li a {

    display: inline;

}

.topnav{

    position:fixed;

    top:0;

    left:0;

    right0;

    height:100px;

    background-color:white;

    color:blue;

}

h3{

    color:black;

}

p{

    color:red;

}

body{

    background-color: white;

    color:aqua;

    font-style: italic;

}

5. Create a repository named assignment12 and push your project to your repository. Submit a link to your assignment repo. (10 marks).