

## STD\*MIS Release 4.0

### Data Dictionary

#### I. Tables

- A. Data files
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#### II. Indexes

- A. Data files
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Table: **ADDRESS.DBF**  
 Type: Data  
 Record length: 179  
 Use: Patient address records

No.	Field	Type	Length	Comment
1	ADDRESS_ID	C	10	Primary key - system generated id number
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	AS_OF	D	8	Date address entered into system
4	STREET_1	C	30	
5	CITY	C	25	(See field CITY in table GEO_AREA for allowable values.)
6	COUNTY	C	20	(See field COUNTY in table GEO_AREA for allowable values.)
7	DISTRICT	C	2	Area of STD administrative responsibility (See field DISTRICT in table GEO_AREA for allowable values.)
8	STATE	C	2	(See field STATE in table GEO_AREA for allowable values.)
9	ZIP	C	5	(See field ZIP in table GEO_AREA for allowable values.)
10	CENSUS_TR	C	8	Census tract
11	COUNTRY	C	30	Country of residence (See field COUNTRY in table GEO_AREA for allowable values).
12	HOME_PHONE	C	12	
13	PROV_FL	L	1	True = provider address, False = patient address
14	ADD_DW	D	8	Date written
15	ADD_TW	C	8	Time written

Table: **AKA.DBF**  
Type: Data  
Record length: 50  
Use: Patient aliases (Aalso known as@)

No.	Field	Type	Length	Comment
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	AKA	C	20	Patient alias or nickname
3	AKA_SNDX	C	4	Soundex of AKA
4	AKA_DW	D	8	Date written
5	AKA_TW	C	8	Time written

Table: **ARCHIVE.DBF**  
Type: Data  
Record length: 93  
Use: Patient-s archived data

No.	Field	Type	Length	Comment
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	REC_ID	C	10	Primary key for archived record
3	EVENT	C	50	Text summary of key fields from archived record.
4	DISK_ID	C	7	Disk id of disk holding archived record
5	ARCHIVE_DW	D	8	Date written
6	ARCHIVE_TW	C	8	Time written

Note: This table is currently not implemented.

Table: **CASE.DBF**  
 Type: Data  
 Record length: 106  
 Use: Diagnosed cases

No.	Field	Type	Length	Comment
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1	CASE_NO	C	10	Primary key - system generated case id
2	MORB_ID	C	10	Foreign key - system generated morbidity id
3	IRB_ID	C	11	Foreign key - system generated interview id
4	FRB_ID	C	11	Foreign key - system generated field record id
5	DISEASE	C	3	Generic disease code (See field DISEASE in table DXCODE for allowable values)
6	DIAGNOSIS	C	3	Specific diagnosis codes (See field DIAGNOSIS in table DXCODE for allowable values)
7	PID	C	1	Pelvic inflammatory disease present? Y = Yes N = No U = Unknown
8	NEURO	C	1	Neuro-syphilis involvement? 1 = Yes, Confirmed 2 = Yes, Probable 3 = No 9 = Unknown
9	CAS_DETECT	C	2	Method of case detection 01 = Provider referral 02 = Cluster referral 03 = Partner referral 04 = Prenatal 05 = Delivery 06 = Institutional screening 07 = Community screening 08 = Reactor 09 = Provider report 10 = Volunteer
10	CONTACT_TO	C	3	If contact, what diagnosis contact to? (See field DIAGNOSIS in table DXCODE for allowable values)
11	PROVIDER	C	20	Name of provider making diagnosis (See field PROVIDER in table PROVIDER for allowable values).

**CASE.DBF (cont.)**

12	PROV_TYPE	C	2	Type of provider making diagnosis (See field TYPE in table PROVIDER for allowable values)
13	DX_DATE	D	8	Date of diagnosis
14	IMPORTED	C	1	Where disease acquired (NETSS codes) 1 = Acquired in USA in reporting state 2 = Acquired outside USA 3 = Acquired in USA, outside of reporting state 9 = Unknown
15	CASE_ENTRY	C	4	Last operator to enter/modify this record (See field USER_ID in table USERS for allowable values)
16	CASE_DW	D	8	Date written
17	CASE_TW	C	8	Time written

Table: **EVENT.DBF**  
Type: Data  
Record length: 26  
Use: Patient STD event

No.	Field	Type	Length	Comment
1	EVENT_ID	C	10	Primary key - system generated event id
2	EVENT_DW	D	8	Date written
3	EVENT_TW	C	8	Time written

Table: **FR.DBF**  
 Type: Data  
 Record length: 115  
 Use: Master field record file

No.	Field	Type	Length	Comment
1	FR_ID	C	10	Primary key - system generated field record id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	ADDRESS_ID	C	10	Foreign key - system generated address id
4	SHORT_ID	C	10	Foreign key - system generated interview-only field record id
5	EVENT_ID	C	10	Foreign key - system generated event id
6	FIRST_EXP	D	8	Date of first exposure (for contacts to disease)
7	FREQ_EXP	C	8	Frequency of exposure (for contacts to disease)
8	LAST_EXP	D	8	Date of last exposure (for contacts to disease)
9	INVEST_AGN	C	20	Investigating agency (See field AGENCY in table AGENCY for allowable values.)
10	LOC_INVEST	C	1	Investigating agency local (within jurisdiction)? Y = Yes, local agency N = No, not local
11	FR_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
12	FR_DW	D	8	Date written
13	FR_TW	C	8	Time written

Table: **FRA.DBF**  
 Type: Data  
 Record length: 172  
 Use: Patient-specific field record data for full field record

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	FR_ID	C	10	Foreign key - system generated field record id
2	FR_NO	C	8	Field record form number (Pre-printed or system generated)
3	FR_AGE	N	3	Patient age at initiation of field record.
4	HEIGHT	C	5	
5	SIZE	C	8	
6	HAIR	C	8	
7	COMPLEXION	C	8	
8	MARITAL_ST	C	1	Marital status D = Divorced M = Married P = Separated S = Single U = Unknown W = Widowed
9	PREGNANT	C	1	Pregnancy status Y = Yes N = No U = Unknown
10	FR_PREG_WK	N	2	If pregnant, number of weeks pregnant
11	EMPLOYER	C	15	
12	WORK_HOURS	C	10	
13	WORK_PHONE	C	12	
14	INIT_AGENCY	C	20	Initiating agency (See field AGENCY in table AGENCY for allowable values).
15	LOC_INIT	C	1	Is initiating agency local (within jurisdiction)? Y = Yes, agency local N = No, not local
16	CLINIC_COD	C	8	Clinic code
17	OOJ_NO	C	8	Tracking number out-of-jurisdiction agency
18	OOJ_AREA	C	20	Out-of-jurisdiction agency (initiating or investigating)
19	DUE_DATE	D	8	Date disposition due on out-of-jurisdiction field record

**FRA.DBF (cont.)**

20	FRA_DW	D	8	Date written
21	FRA_TW	C	8	Time written

Table: **FRB.DBF**  
 Type: Data  
 Record length: 41  
 Use: Field record disposition data

No.	Field	Type	Length	Comment
1	FRB_ID	C	11	Primary key - system generated FRB id
2	DISPO	C	1	Disposition

STD Dispositions:  
 A = Preventive treatment  
 B = Refused preventive treatment  
 C = Infected, brought to treatment  
 D = Infected, not treated  
 E = Previous treatment  
 F = Not infected  
 G = Insufficient information to begin invest.  
 H = Unable to locate  
 J = Located, refused exam  
 K = Out of jurisdiction  
 L = Other

HIV Dispositions:  
 1 = Previous positive  
 2 = Prev. negative, new positive  
 3 = Prev. negative, still negative  
 4 = Prev. negative, no test  
 5 = No prev. test, new positive  
 6 = No prev. test, new negative  
 7 = No prev. test, no test  
 G = Insufficient information to begin invest.  
 H = Unable to locate  
 J = Located, refused exam  
 K = Out of jurisdiction  
 L = Other

Hepatitis Dispositions:  
 M = Negative test  
 N = No test, vaccine #1  
 O = Acute infected  
 P = Neg. test, refused vaccine  
 Q = No test, refused vaccine  
 R = Chronic infected  
 S = Vaccine #2  
 T = Vaccine #3

**FRB.DBF (.cont)**

U = Neg. test, vaccine #1 & HBIG  
 V = No test, vaccine #1 & HBIG  
 W = Neg. test, HBIG only  
 X = No test, HBIG only  
 Y = Neg. test, out of incubation  
 Z = Known infection  
 G = Insufficient information to begin invest.  
 H = Unable to locate  
 J = Located, refused exam  
 K = Out of jurisdiction  
 L = Other

3	DISPO_DT	D	8	Disposition date
4	WORKER	C	3	Dispositioning worker (See field WORKERNO in table WORKER for allowable values).
5	SOURCE_SPR	C	1	Source/spread (only available for entry on interview-only field records). 1 = Source of infection 2 = Spread of infection 9 = Unknown
6	POST_CNLS	C	1	Post-test counseled for HIV infection? Y = Yes N = No U = Unknown
7	FRB_DW	D	8	Date written
8	FRB_TW	C	8	Time written

Table: **FUPLOG.DBF**  
 Type: Data  
 Record length: 80  
 Use: Surveillance follow-up log

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	EVENT_ID	C	10	Foreign key - system generated event id
2	MORB_ID	C	10	Foreign key - system generated morbidity id
3	REACTOR_ID	C	10	Foreign key - system generated reactor id
4	PATIENT_ID	C	10	Foreign key - system generated patient id
5	ASSIGN_DT	D	8	Date assigned
6	ASSIGN_TO	C	3	Assigned to worker (See field WORKENO in table WORKER for allowable values).
7	STATUS	C	1	Log status O = Open C = Closed
8	CLOSE_DT	D	8	Date closed
9	FUP_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
10	FUP_DW	D	8	Date written
11	FUP_TW	C	8	Time written

Table: **F\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for field records

No.	Field	Type	Length	Comment
1	FR_ID	C	10	Foreign key - system generated field record id

Note: Structure of this file will vary according to local needs.

Table: **HISTORY.DBF**  
 Type: Data  
 Record length: 65  
 Use: Clinic visit diagnoses

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	HISTORY_ID	C	10	Primary key - system generated history id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	DISEASE	C	3	Generic disease code (See field DISEASE in table DXCODE for allowable values.)
5	DIAGNOSIS	C	3	Specific diagnosis (See field DIAGNOSIS in table DXCODE for allowable values.)
6	CURRENT	C	1	Current diagnosis? Y = Yes N = No
7	DATE_PREV	C	8	Date of previous diagnosis
8	HIS_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
9	HIS_DW	D	8	Date written
10	HIS_TW	C	8	Time written

Table: **HOLD.DBF**  
Type: Data  
Record length: 5  
Use: Records held for supervisor review

No.	Field	Type	Length	Comment
1	MORB_ID	C	10	Foreign key - system generated morbidity id
2	REACTOR_ID	C	10	Foreign key - system generated reactor id
3	OOJ_ID	C	10	Foreign key - system generated OOJ id
4	IX_ID	C	10	Foreign key - system generated interview id
5	HOLD_DW	D	8	Date written
6	HOLD_TW	C	8	Time written

Table: **IRA.DBF**  
 Type: Data  
 Record length: 168  
 Use: Patient-specific interview data

No.	Field	Type	Length	Comment
1	IX_ID	C	10	Primary key - system generated interview id
2	EVENT_ID	C	10	Foreign key - system generated event id
3	PATIENT_ID	C	10	Foreign key - system generated patient id
4	ADDRESS_ID	C	10	Foreign key - system generated address id
5	CONTROL_NO	C	8	Interview form control number (pre-printed or system generated)
6	AGE	N	3	Age at interview.
7	PREGNANT	C	1	Pregnancy status Y = Yes N = No U = Unknown
8	PREG_WKS	N	2	Number weeks pregnant
9	IR_BIRTH	C	1	Given birth in past year? Y = Yes N = No U = Unknown
10	SUPV_NO	C	3	Supervisor number
11	CLINIC_COD	C	8	Clinic code
12	MED_REC_NO	C	10	Medical record number
13	PRE_CNSL	C	1	Pre-test counseled? Y = Yes N = No U = Unknown
14	POST_CNSL	C	1	Post-test counseled? Y = Yes N = No U = Unknown
15	HIV_TEST	C	1	HIV test done? Y = Yes N = No R = Refused U = Unknown

**IRA.DBF (cont.)**

16	PRE_HIV	C	1	Previous HIV test result X = No previous test P = Positive N = Negative I = Indeterminate U = Unknown results
17	PRE_HIV_DT	D	8	Date of previous HIV test
18	PRE_CODE	C	2	Provider code for previous HIV test (See field TYPE in table PROVIDER for allowable values).
19	PRE_NAME	C	20	Provider for previous HIV test (See field PROVIDER in table PROVIDER for allowable values).
20	CUR_HIV	C	1	Current HIV test results P = Positive N = Negative I = Indeterminate U = Unknown results
21	CUR_HIV_DT	D	8	Date of current HIV test
22	CUR_CODE	C	2	Provider code for current HIV test (See field TYPE in table PROVIDER for allowable values).
23	CUR_NAME	C	20	Provider for current HIV test (See field PROVIDER in table PROVIDER for allowable values).
24	OTH_INF_1	C	3	Other infection 1 (See field DIAGNOSIS in table DXCODE for allowable values.)
25	OTH_INF_2	C	3	Other infection 2 (See field DIAGNOSIS in table DXCODE for allowable values.)
26	GEND_PART	C	1	Gender of sex partners last 12 months? M = Male F = Female B = Both R = Refused U = Unknown
27	IRA_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
28	IRA_DW	D	8	Date written
29	IRA_TW	C	8	Time written

Table: **IRB.DBF**  
 Type: Data  
 Record length: 88  
 Use: Disease-specific interview data

No.	Field	Type	Length	Comment
1	IRB_ID	C	11	Primary key - IX_ID + sequence number ( 1 = disease 1, 2 = disease 2)
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	IX_ID	C	10	Foreign key - system generated interview id
4	INFORM_ID	C	10	Case number for index case (original patient)
5	ASSIGN_DT	D	8	Date interview assigned
6	ASSIGN_TO	C	3	Worker interview assigned to (See field WORKERNO in table WORKER for allowable values).
7	CASE_IX	C	1	Case interviewed? C = Clinic F = Field U = Unable to locate R = Located, refused O = Other
8	IX_PERIOD	N	2	Interview period
9	SEX_PART	N	3	Number of sex partners acknowledged in time period
10	NS_PART	N	3	Number of needle-sharing partners acknowledged in time period
11	BOTH_PART	N	3	Number of partners acknowledged in time period with whom shared sex and needles
12	CLOSED_DT	D	8	Date interview closed
13	IRB_DW	D	8	Date written
14	IRB_TW	C	8	Time written

Table: **I\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for interview records

No.	Field	Type	Length	Comment
1	IX_ID	C	10	Foreign key - system generated interview id

Note: Structure of this file will vary according to local needs.

Table: **MORBREPT.DBF**  
 Type: Data  
 Record length: 78  
 Use: Morbidity records

No.	Field	Type	Length	Comment
1	MORB_ID	C	10	Primary key - system generated morbidity id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	ADDRESS_ID	C	10	Foreign key - system generated address id
4	EVENT_ID	C	10	Foreign key - system generated event id
5	ORIGIN	C	1	Origin of morbidity report M = Morbidity report L = Lab report I = Interview C = Clinic visit F = Field record
6	MMWR_WEEK	C	2	CDC Morbidity and Mortality Weekly Report reporting week
7	MMWR_YEAR	C	2	CDC Morbidity and Mortality Weekly Report reporting week
8	REPT_DT	D	8	Date of case report to health department
9	PREGNANT	C	1	Pregnancy status Y = Yes N = No U = Unknown
10	MORB_AGE	N	3	Age at diagnosis
11	NAMED	L	1	Named or non-named morbidity? T = Named F = Non-named
12	MORB_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
13	MORB_DW	D	8	Date written
14	MORB_TW	C	8	Time written

Table: **M\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for morbidity records

No.	Field	Type	Length	Comment
1	MORB_ID	C	10	Foreign key - system generated morbidity id

Note: Structure of this file will vary according to local needs.

Table: **NOTES.DBF**  
Type: Data  
Record length: 46  
Use: Patient notes

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	EVENT_ID	C	10	Foreign key - system generated event id
3	NOTES	M	10	Memo field for notes
4	NOTES_DW	D	8	Date written
5	NOTES_TW	C	8	Time written

Table: **OOJLOG.DBF**  
 Type: Data  
 Record length: 238  
 Use: Out-of-jurisdiction records tracking log.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	OOJ_ID	C	10	Primary key - system generated OOI log id
2	EVENT_ID	C	10	Foreign key - system generated event id
3	PATIENT_ID	C	10	Foreign key - system generated patient id
4	ADDRESS_ID	C	10	Foreign key - system generated address id
5	OOJ_TYPE	C	1	Type of OOI I = Incoming O = Outgoing
6	OOJ_DISEAS	C	3	Disease code (See field DISEASE in table DXCODE for allowable values.)
7	OOJ_DX	C	3	Diagnosis code (See field DIAGNOSIS in table DXCODE for allowable values.)
8	PROCESS_BY	C	4	Login id of operator making initial log entry
9	PROCESS_DT	D	8	Date OOI log initially entered
10	REF_BASIS	C	2	Referral basis (See field REF_BASIS in table REFERRAL for allowable values.)
11	INIT_AGENCY	C	20	Initiating agency (See field AGENCY in table AGENCY for allowable values).
12	LOC_INIT	C	1	Initiating agency local (within jurisdiction)? Y = Yes, agency is local N = No, agency not local
13	INVEST_AGN	C	20	Investigating agency (See field AGENCY in table AGENCY for allowable values).
14	LOC_INVEST	C	1	Investigating agency local (within jurisdiction)? Y = Yes, agency local N = No, agency not local
15	OOJ_AGE	N	3	Patient age
16	HEIGHT	C	4	
17	SIZE	C	8	
18	HAIR	C	8	
19	COMPLEXION	C	8	

**OOJLOG.DBF (cont.)**

20	MARITAL_ST	C	1	Marital status D = Divorced M = Married P = Separated S = Single U = Unknown W = Widowed
21	PREGNANT	C	1	Pregnancy status Y = Yes N = No U = Unknown
22	EMPLOYER	C	15	
23	WORK_HOURS	C	10	
24	WORK_PHONE	C	12	
25	FIRST_EXP	D	8	Date of first exposure (partners only)
26	FREQ_EXP	C	8	Frequency of exposure (partners only)
27	LAST_EXP	D	8	Date of last exposure (partners only)
28	LOC_FR_NO	C	8	Local field record number
29	DUE_DATE	D	8	Date disposition due
30	STATUS	C	1	Log status O = Open C = Closed
31	CLOSE_DT	D	8	Date log entry closed
32	OOJ_DW	D	8	Date written
33	OOJ_TW	C	8	Time written

Table: **PATIENT.DBF**  
 Type: Data  
 Record length: 149  
 Use: Patient identifying and demographic data.

No.	Field	Type	Length	Comment
1	PATIENT_ID	C	10	Primary key - system generated patient id
2	LAST_NAME	C	20	
3	FIRST_NAME	C	20	
4	M_INITIAL	C	1	
5	F_L_SNDX	C	8	Soundex of first and last names
6	F_SNDX	C	4	Soundex of first name
7	DOB	D	8	Date of birth
8	SSN	C	11	Social security number
9	SEX	C	1	Sex codes: 1 = Male 2 = Female 9 = Unknown
10	RACE	C	1	Race codes: 1 = Amer. Indian/Alaskan Native 2 = Asian/Pacific Isl. 3 = Black 4 = White 7 = Multi-racial 8 = Other 9 = Unknown
11	MULT_RACES	C	13	Text string combination of selected race codes
12	RACE_TYPE	C	1	Local use race type (currently not used).
13	ETHNICITY	C	1	Ethnicity code: 1 = Hispanic 2 = Non-hispanic 9 = Unknown
14	MED_REC_NO	C	10	Medical record number.
15	HARS_ID	C	10	HIV/AIDS Registry System patient id number
16	ARCHIVE	L	1	Patient has archived records? (currently not used) T = Yes, patient has archived records F = No, patient has no archived records
17	TEMP_DOB	D	8	Calculated DOB based on age (used if true DOB unknown)

**PATIENT.DBF (cont.)**

18	NAMED	L	1	Is patient a named record? T = Yes, patient is a named record F = False, patient is a non-named record.
19	PAT_ENTRY	C	4	Last operator to enter/modify record. (See field USER_ID in table USERS for allowable values).
20	PAT_DW	D	8	Date written
21	PAT_TW	C	8	Time written

Table: **P\_LINK.DBF**  
Type: Data  
Record length: 36  
Use: Patient cross-reference links

No.	Field	Type	Length	Comment
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	REL_ID	C	10	Patient id of related patient
3	PLINK_DW	D	8	Date written
4	PLINK_TW	C	8	Time written

Table: **REACTOR.DBF**  
 Type: Data  
 Record length: 81  
 Use: Positive lab tests for surveillance processing

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	REACTOR_ID	C	10	Primary key - system generated reactor id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	DISEASE	C	3	Disease code of test(s) (See field DISEASE in table DXCODE for allowable values).
5	RECEIVE_DT	D	8	Date lab report received by HD
6	RECEIVE_BY	C	3	Worker number of person processing lab report (See field WORKERNO in table WORKER for allowable values).
7	PRIORITY	C	15	Priority for followup (See field PRIORITY in table PRIORITY for allowable values).
8	NUM_TESTS	N	2	Number of tests on lab report
9	REACT_ENT	C	4	Last operator to create/modify record (See field USER_ID in table USERS for allowable values).
10	REACT_DW	D	8	Date written
11	REACT_TW	C	8	Time written

Table: **REFERRAL.DBF**  
 Type: Data  
 Record length: 89  
 Use: Referral data for field records

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	FR_ID	C	10	Foreign key - system generated field record id
2	DISEASE_NO	C	1	Field record disease number (1 or 2)
3	FRB_ID	C	11	Foreign key - System generated FRB id
4	CASE_NO	C	10	Foreign key - Case number of initiating case (case number of original patient)
5	REACTOR_ID	C	10	Foreign key - Id number of initiating reactor
6	OOJ_ID	C	10	Foreign key - Id number of initiating OOJ log record
7	REF_DISEAS	C	3	Referral disease (if not initiated from another event) (See field DISEASE in table DXCODE for allowable values).
8	REF_DX	C	3	Referral diagnosis (if not initiated from another event) (See field DIAGNOSIS in table DXCODE for allowable values).
9	REF_BASIS	C	2	Referral basis: P1 = Sex partner P2 = Needle-sharing partner P3 = Both (sex and needle-sharing) A1 = Associate A2 = Associate A3 = Associate S1 = Suspect S2 = Suspect S3 = Suspect T1 = Positive lab test T2 = Morbidity report O1 = OOJ partner O2 = OOJ cluster O3 = OOJ reactor F = Generic followup N = NCI (no contacts initiated)
10	TYPE_REF	C	1	Type of referral 1 = Patient referral 2 = Provider referral

**REFERRAL.DBF (cont.)**

11	INTERVIEWR	C	3	Worker number of initiating worker (See field WORKERNO in table WORKER for allowable values).
12	INIT_DT	D	8	Date initiated
13	TYPE_IX	C	1	Type of interview: O = Original R = Re-interview C = Cluster P = Post-test U = Unable to interview
14	REF_DW	D	8	Date written
15	REF_TW	C	8	Time written

Table: **REVIEW.DBF**  
Type: Data  
Record length: 36  
Use: Imported lab records awaiting review for follow-up

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	PATIENT_ID	C	10	Foreign key - local system generated patient id
2	EVENT_ID	C	10	Foreign key - local system generated event id
3	REVIEW_DW	D	8	Date written
4	REVIEW_TW	C	8	Time written

Table: **REMOTE.DBF**  
 Type: Data  
 Record length: 120  
 Use: Uploaded patient history summary

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	SITE	C	2	STD*MIS site where original record resides
2	PATIENT_ID	C	10	Foreign key - local system generated patient id
3	REC_TYPE	C	2	Record type MO = Morbidity VI = Clinic visits CS = Congenital IR = Interview FR = Field records TE = Lab tests RX = Treatments AK = Aka's
4	REC_ID	C	10	Primary key of source record from remote site
5	EVENT	C	80	Summary containing event key fields
6	REMOTE_DW	D	8	Date written
7	REMOTE_TW	C	8	Time written

Table: **RISK.DBF**  
 Type: Data  
 Record length: 75  
 Use: Patient risk factors

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RISK_ID	C	10	Primary key - system generated risk id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	RISK	C	25	Risk factor (See field RISK in table RISKCODE for allowable values)
5	RISK_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
6	RIS_DW	D	8	Date written
7	RIS_TW	C	8	Time written

Table: **RX.DBF**  
 Type: Data  
 Record length: 100  
 Use: Patient treatment records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	RX_ID	C	10	Primary key - system generated rx id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	RX_DATE	D	8	Treatment date
5	PROVIDER	C	20	Name of provide providing treatment (See field PROVIDER in table PROVIDER for allowable values).
6	RX	C	30	Treatment (See field RX in table RXCODE for allowable values.)
7	RX_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
8	RX_DW	D	8	Date written
9	RX_TW	C	8	Time written

Table: **R\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for treatment records

No.	Field	Type	Length	Comment
1	RX_ID	C	10	Foreign key - system generated treatment id

Note: Structure of this file will vary according to local needs.

Table: **SHORTFR.DBF**  
Type: Data  
Record length: 55  
Use: Patient data for interview-only field records.

No.	Field	Type	Length	Comment
1	SHORT_ID	C	10	Primary key - system generated short FR id
2	FR_NO	C	8	Pre-printed or system generated field record form no.
3	NAME	C	20	
4	SEX	C	1	Sex code: 1 = Male 2 = Female 9 = Unknown
5	SHORT_DW	D	8	Date written
6	SHORT_TW	C	8	Time written

Table: **SIGNS.DBF**  
 Type: Data  
 Record length: 69  
 Use: Patient clinical signs

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	SIGNS_ID	C	10	Primary key - system generated signs id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	SIGNS	C	20	Clinician diagnosed sign (See field SIGNS in table SIGNCODE for allowable values).
5	SIGN_ENTRY	C	3	Last operator to create/modify record (See field USER_ID in table USERS for allowable values).
6	SIGNS_DW	D	8	Date written
7	SIGNS_TW	C	8	Time written

Table: **STD126.DBF**  
 Type: Data  
 Record length: 386  
 Use: Congenital syphilis record.

No.	Field	Type	Length	Comment
1	CS_ID	C	10	System generated primary key
2	SITE	C	2	STD*MIS site code where record entered
3	CASEID	C	7	Locally determined case id number (preferably the 126 Report form Case Id number).
4	PATIENT_ID	C	10	Foreign key - system generated patient id for infant
5	MOTHER_ID	C	10	Foreign key - system generated patient id for mother
6	ADDRESS_ID	C	10	Foreign key - system generated address id number for infant
7	MOM_ADD_ID	C	10	Foreign key - system generated address id number for mother
8	EVENT_ID	C	10	Foreign key - system generated STD event id
9	MORB_ID	C	10	Foreign key - system generated morbidity id
10	M_CHART	C	10	Mother's chart number
11	I_CHART	C	10	Infant's chart number
12	DELIVER_MD	C	20	Delivering physician (See field PROVIDER in table PROVIDER for allowable values).
13	MD_TYPE	C	2	Provider type - delivering physician (See field TYPE in table PROVIDER for allowable values).
14	DEL_PHONE	C	12	Phone number - delivering physician
15	PEDIATRICI	C	20	Pediatrician's name (See field PROVIDER in table PROVIDER for allowable values).
16	PED_PHONE	C	12	Pediatrician's phone number
17	LOCALID	C	7	Local id number
18	REPORT_DT	D	8	Report date
19	STNAME	C	2	Reporting state (See field STATE in table GEO_AREA for allowable values.)
20	CNTYNM	C	20	Reporting county (See field COUNTY in table GEO_AREA for allowable values.)

**STD126.DBF (cont.)**

21	CITYNM	C	20	Reporting city (See field CITY in table GEO_AREA for allowable values.)
22	OTHERGEO	C	3	Other reporting geographic area
23	SENTINEL	C	1	Sentinel site for congenital syphilis surveillance? 1 = Yes 2 = No 9 = Unknown
24	MARITAL	C	1	Marital status 1 = Single, never married 2 = Married 3 = Separated, divorced 4 = Widowed 8 = Other 9 = Unknown
25	LMP_DT	D	8	Date last menstrual period
26	PRENATAL	C	1	Prenatal care? 1 = Yes 2 = No 9 = Unknown
27	PNC_DT	D	8	Date first prenatal care visit
28	PNCNUM	N	2	Number of prenatal care visits
29	NONTREP	C	1	Mother have nontreponemal test? 1 = Yes 2 = No 9 = Unknown
30	TEST_A_DT	D	8	Test date - nontreponemal test
31	RESULTA	C	1	Test result - nontreponemal test R = Reactive N = Non-reactive U = Unknown
32	TITER_A	N	4	Titer closest to delivery
33	TEST_B_DT	D	8	Test date - nontreponemal test
34	RESULTB	C	1	Test result - nontreponemal test See field RESULTA for valid codes.
35	TITER_B	N	4	Titer.
36	TEST_C_DT	D	8	Test date - nontreponemal test
37	RESULTC	C	1	Test result - nontreponemal test See field RESULTA for valid codes.
38	TITER_C	N	4	Titer.
39	TEST_D_DT	D	8	Test date - nontreponemal test

**STD126.DBF (cont.)**

40	RESULTD	C	1	Test result - nontreponemal test See field RESULTA for valid codes.
41	TITER_D	N	4	Titer
42	TREPONEM	C	1	Treponemal test done? 1 = Yes, reactive 2 = Yes, nonreactive 3 = No test 9 = Unknown
43	LESIONS	C	1	Exam of lesions at delivery? 1 = Yes, positive 2 = Yes, negative 3 = No test 9 = Unknown
44	LASTREAT	C	1	Last treatment for syphilis 1 = Before pregnancy 2 = During pregnancy 3 = No treatment 9 = Unknown
45	LAST_RX_DT	D	8	Date of last syphilis treatment
46	TXADQBEF	C	1	Treatment adequate before pregnancy? 1 = Yes, adequate 2 = No, inadequate 9 = Unknown
47	TXADQDUR	C	1	Treatment adequate during pregnancy? 1 = Yes 2 = No, non-penicillin therapy 3 = No, penicillin begun < 30 days before delivery 4 = Unknown
48	RESPAPPR	C	1	Appropriate serologic response? 1 = Yes 2 = Yes, but no followup titers during pregnancy 3 = No, inappropriate response 4 = No, equivocal response
49	VITAL	C	1	Vital status 1 = Alive 2 = Born alive, then died 3 = Stillborn 9 = Unknown
50	DEATH_DT	D	8	Date of death
51	BIRTHWT	N	4	Birth weight in grams

**STD126.DBF (cont.)**

52	AGE	N	2	Estimated gestational age (in weeks)
53	REACSTS	C	1	Infant have reactive serology? 1 = Yes 2 = No 9 = Unknown
54	REACT_DT	D	8	Date reactive test
55	INF_TITER	N	4	Titer of infant serology
56	REACT_TREP	C	1	Infant have reactive treponemal test? 1 = Yes 2 = No 9 = Unknown
57	TREP_DT	D	8	Date of reactive treponemal test?
58	SIGNSCS	C	1	Infant have classic signs of CS? 1 = Yes 2 = No, asymptomatic 9 = Unknown
59	DARKFLD	C	1	Infant have darkfield exam? 1 = Yes, positive 2 = Yes, negative 3 = No test 9 = Unknown
60	DFA	C	1	Infant have DFA test? 1 = Yes, positive 2 = Yes, negative 3 = No test 9 = Unknown
61	IGM	C	1	Infant have IgM-specific treponemal test? 1 = Yes, reactive 2 = Yes, nonreactive 3 = No test 9 = Unknown
62	XRAYs	C	1	Infant have long bone xrays? 1 = Yes, changes consistent with CS 2 = Yes, no signs of CS 3 = No xrays 9 = Unknown
63	CSFVDRL	C	1	Infant have CDS-VDRL? 1 = Yes, reactive 2 = Yes, nonreactive 3 = No test 9 = Unknown

**STD126.DBF (cont.)**

64	CSFCOUNT	C	1	Infant have CSF cell count or protein test? 1 = Yes, one or both elevated 2 = Yes, both not elevated 3 = No test 9 = Unknown
65	TREATED	C	1	Infant treated? 1 = Yes, w/ Aqueous or Procaine penicillin for > 10 days 2 = Yes, with Ampicillin followed by Aqueous/Procaine pen. for >= 10 days 3 = Yes, with Benzathine penicillin X 1 4 = Yes, with other treatment 5 = No treatment 9 = Unknown
66	CLASS	C	1	Case classification: 1 = Not a case 2 = Confirmed case 3 = Syphilitic stillbirth 4 = Presumptive case
67	VERSION	C	7	Version of form data entered from
68	CS_ENTRY	C	4	Last operator to enter/modify record (See field USER_ID in table USERS for allowable values).
69	STD_DW	D	8	Date written
70	STD_TW	C	8	Time written

Table: **SURVCLOS.DBF**  
 Type: Data  
 Record length: 37  
 Use: Positive test surveillance closure records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	REACTOR_ID	C	10	Foreign key - system generated reactor id
2	MORB_ID	C	10	Foreign key - system generated morbidity id
3	SURV_DISPO	C	1	Surveillance disposition A = Administrative closure P = Physician contact closure R = Record search closure B = Biological false positive closure
4	SURV_DW	D	8	Date written
5	SURV_TW	C	8	Time written

Table: **SYMPTOMS.DBF**  
 Type: Data  
 Record length: 77  
 Use: Patient symptom record.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	SYMPTOM_ID	C	10	Primary key - system generated symptom id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	EVENT_ID	C	10	Foreign key - system generated event id
4	ONSET_DT	D	8	Onset date of symptom
5	DURATION	N	4	Duration of symptom
5	SYM_DESCR	C	15	Description of symptom (See field SYMPTOM in table SYMPCODE for allowable values).
6	SYM_ENTRY	C	4	Last operator to create/modify record (See field USER_ID in table USERS for allowable values).
7	SYM_DW	D	8	Date written
8	SYM_TW	C	8	Time written

Table: **TEST.DBF**  
 Type: Data  
 Record length: 187  
 Use: Patient lab test records

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	TEST_ID	C	10	Primary key - system generated test id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	ADDRESS_ID	C	10	Foreign key - system generated address id
4	EVENT_ID	C	10	Foreign key - system generated event id
5	REACTOR_ID	C	10	Foreign key - system generated reactor id
6	RECEIVE_DT	D	8	For tests entered directly from lab report, date test result received at HD
7	AGE	N	3	Patient age at time of test
8	LAB	C	20	Lab performing test (See field LAB in table LABCODE for allowable values).
9	PROVIDER	C	20	Provider collecting specimen (See field PROVIDER in table PROVIDER for allowable values).
10	PROV_TYPE	C	2	Provider type (See field TYPE in table PROVIDER for allowable values).
11	COLLECT_DT	D	8	Date specimen collected
12	TEST_DATE	D	8	Date lab analysis performed
13	TEST_TYPE	C	10	Type of test (See field TEST_TYPE in table TESTTYPE for allowable values).
14	TEST_SITE	C	10	Anatomical site where specimen obtained (See field SPECIMEN in table SPECIMEN for allowable values).
15	TEST_DISEA	C	3	Generic disease code for which test is done (See field DISEASE in table DXCODE for allowable values).
16	QUAL_RESUL	C	1	Qualitative result P = Positive N = Negative I = Indeterminate U = Unsatisfactory C = Contaminated A = Awaiting results O = Other
17	QUAN_RESUL	C	8	Quantitative result

**TEST.DBF (cont.)**

18	NAMED	L	1	Test done on named patient? T = Test done on named patient F = Test done on anonymous patient
19	ACCESS_NO	C	15	Laboratory accession number.
19	TEST_ENTRY	C	4	Last operator to create/modify record (See field USER_ID in table USERS for allowable values).
20	TEST_DW	D	8	Date written
21	TEST_TW	C	8	Time written

Table: **T\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for lab test records

No.	Field	Type	Length	Comment
1	TEST_ID	C	10	Foreign key - system generated test id

Note: Structure of this file will vary according to local needs.

Table: **VISIT.DBF**  
 Type: Data  
 Record length: 134  
 Use: Patient clinic visit records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	VISIT_ID	C	10	Primary key - system generated visit id
2	PATIENT_ID	C	10	Foreign key - system generated patient id
3	ADDRESS_ID	C	10	Foreign key - system generated address id
4	EVENT_ID	C	10	Foreign key - system generated event id
5	VISIT_AGE	N	3	Patient age at visit
6	VISIT_DT	D	8	Visit date
7	REASON	C	15	Reason for visit (See field REASON in table VREASON for allowable values.)
8	CLINIC	C	20	Name of clinic (See field PROVIDER in table PROVIDER for allowable values.)
9	CLINIC_TYP	C	2	Clinic type (See field TYPE in table PROVIDER for allowable values.)
10	CLINICIAN	C	20	Clinician name (See field NAME in table CLINICMD for allowable values.)
11	INSURANCE	C	1	Type of insurance F = Fee pay/private H = HMO M = Medicaid N = Not insured O = Other U = Unknown
12	PREGNANT	C	1	Pregnancy status Y = Yes N = No U = Unknown
13	INFERTILE	C	1	Infertile? Y = Yes N = No U = Unknown
14	PRE_CNSL	C	1	Pre-test counseled for HIV? Y = Yes N = No U = Unknown

**VISIT.DBF (cont.)**

15	POST_CNLSL	C	1	Post-test counseled for HIV? Y = Yes N = No U = Unknown
16	NAMED	L	1	Visit for named or non-named patient? (Currently, all visit records are for named patients). T = Named patient F = Anonymous patient
17	VIS_ENTRY	C	4	Last operator to create/modify record (See field USER_ID in table USERS for allowable values).
18	VIS_DW	D	8	Date written
19	VIS_TW	C	8	Time written

Table: **V\_LOCAL.DBF**  
Type: Data  
Record length: Variable  
Use: Local use database for clinic visit records

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	VISIT_ID	C	10	Primary key - system generated visit id

Note: Structure of this file will vary according to local needs.

Table: **AGENCY.DBF**  
 Type: Reference  
 Record length: 37  
 Use: STD control administrative areas

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	AGENCY	C	20	Area of STD administrative responsibility
2	LOCAL	C	1	Agency local or out-of-jurisdiction? Y = Local agency N = Out-of-jurisdiction agency
3	AGENCY_DW	D	8	Date written
4	AGENCY_TW	C	8	Time written

Table: **CLINICMD.DBF**  
 Type: Reference  
 Record length: 38  
 Use: Medical care providers working at clinic

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	NAME	C	20	Primary key - name of clinic provider
2	TYPE	C	2	Type of clinic provider NP = Nurse practitioner MD = Physician PA = Physician assistant PN = Practical nurse RN = Registered nurse OT = Other UN = Unknown
3	CLIN_DW	D	8	Date written
4	CLIN_TW	C	8	Time written

Table: **DXCODE.DBF**  
 Type: Reference  
 Record length: 48  
 Use: STD diagnosis and disease codes

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	DISEASE	C	3	Generic disease code 070 = Hepatitis 100 = Chancroid 200 = Chlamydia 300 = Gonorrhea 400 = NGU 410 = Pediculosis 420 = Scabies 450 = MPC 460 = Bacterial Vaginosis 470 = Trichomoniasis 480 = Candidiasis 490 = PID syndrome 500 = Granuloma Inguinale 600 = LGV 700 = Syphilis 800 = Genital warts 850 = Genital herpes 900 = HIV infection
2	DIAGNOSIS	C	3	Primary key - specific diagnosis 030 = HepB acute w/o delta 031 = HepB acute w/ delta 033 = HepB chronic w/o delta 034 = HepB chronic w/ delta 042 = Hepatitis delta 051 = Hepatitis C, acute 053 = Hepatitis E 054 = Hepatitis C, chronic 070 = Hepatitis, unknown 100 = Chancroid 200 = Chlamydia 300 = Gonorrhea 350 = Resistant gonorrhea 400 = NGU 410 = Pediculosis 420 = Scabies 450 = MPC

**DXCODE.DBF (cont.)**

				460 = Bacterial Vaginosis
				470 = Trichomoniasis
				480 = Candidiasis
				490 = PID syndrome
				500 = Granuloma inguinale
				600 = LGV
				700 = Syphilis, unknown
				710 = Syphilis, primary
				720 = Syphilis, secondary
				730 = Syphilis, early latent
				740 = Syphilis, unknown latency
				745 = Syphilis, late latency
				750 = Syphilis, late w/ symptoms
				760 = Syphilis, neuro-
				790 = Syphilis, congenital
				800 = Genital warts
				850 = Genital herpes
				900 = HIV infection
				950 = AIDS
3	DESCRIP	C	20	Text description of diagnosis
4	SEX	C	1	Allowable sex codes for sex-specific diagnoses
				1 = Males only
				2 = Females only
				9 = Not sex-specific
5	NETSS_CODE	C	5	Netss translation code for diagnosis
				10273 = Chancroid
				10274 = Chlamydia
				10276 = Granuloma inguinale
				10280 = Gonorrhea, resistant gonorrhea
				10306 = LGV
				10307 = NGU
				10308 = MPC
				10309 = PID syndrome
				10311 = Syphilis, primary
				10312 = Syphilis, secondary
				10313 = Syphilis, early latent
				10314 = Syphilis, late latency
				10315 = Syphilis, unknown latency
				10316 = Syphilis, congenital
				10318 = Syphilis, late with symptoms
				88888 = All other diseases
6	DX_DW	D	8	Date written
7	DX_TW	C	8	Time written

Table: **GEO\_AREA.DBF**  
 Type: Reference  
 Record length: 111  
 Use: City/county/zip code/state file

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	CITY	C	25	City name
2	CITY_FIPS	C	4	City FIPS code
3	COUNTY	C	20	County name
4	CNTY_FIPS	C	3	County FIPS code
5	ZIPCODE	C	5	Zip code
6	DISTRICT	C	2	Area of STD Control program administrative responsibility
7	STATE	C	2	State postal abbreviation
8	STATE_FIPS	C	2	State FIPS code
9	COUNTRY	C	30	Country name
10	CNTRY_FIPS	C	2	Country FIPS code
11	GEO_DW	D	8	Date written
12	GEO_TW	C	8	Time written

Table: **LABCODE.DBF**  
 Type: Reference  
 Record length: 165  
 Use: Laboratory directory.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	LAB	C	20	Primary key - name of lab
2	STREET1	C	30	
3	STREET2	C	30	
4	CITY	C	20	
5	STATE	C	2	
6	ZIP	C	5	
7	PHONE	C	12	
8	DISTRICT	C	2	Area of STD Control program administrative responsibility
9	ID_NO	C	8	Locally assigned id number
10	CONTACT	C	20	Laboratory contact person
11	DATEWRIT	D	8	Date written
12	TIMEWRIT	C	8	Time written

Table: **PRIORITY.DBF**  
Type: Reference  
Record length: 31  
Use: Positive test follow-up priority

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	PRIORITY	C	15	Primary key - follow-up priorities for positive tests. (Allowable values determined locally.)
2	PRIOR_DW	D	8	Date written
3	PRIOR_TW	C	8	Time written

Table: **PROVIDER.DBF**  
 Type: Reference  
 Record length: 168  
 Use: Provider directory

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	PROVIDER	C	20	Primary key - provider name
2	STREET1	C	30	
3	STREET2	C	30	
4	CITY	C	20	
5	STATE	C	2	
6	ZIP	C	5	
7	PHONE	C	12	
8	DISTRICT	C	2	Area of STD Control Program administrative responsibility
9	TYPE	C	2	Provider type: 01 = HIV counseling/testing site 02 = STD clinic 03 = Drug treatment 04 = Family planning 05 = Prenatal/Obstetrics 06 = TB clinic 07 = Other clinic 08 = Private MD/HMO 09 = Hospital (inpatient) 10 = Emergency room 11 = Correctional facility 12 = Lab 13 = Blood bank 14 = Delivery 15 = Prenatal 16 = Job Corps 17 = School-based clinic 18 = Mental Health provider 66 = Indian Health Service 77 = Military 88 = Other 99 = Unknown
10	ID_NO	C	8	Local id number
11	STUDY_TYPE	C	1	Study type for regional infertility project P = Prevalence S = Screening N = Not participating

**PROVIDER.DBF (cont.)**

12	CONTACT	C	20	Provider contact person
13	DATEWRIT	D	8	Date written
14	TIMEWRIT	C	8	Time written

Table: **RACETYPE.DBF**  
Type: Reference  
Record length: 27  
Use: Locally defined race/ethnicity types

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RACE_TYPE	C	1	Race code (locally defined)
2	DESCRIP	C	10	Race description
3	RACE_DW	D	8	Date written
4	RACE_TW	C	8	Time written

Table: **RISKCODE.DBF**  
Type: Reference  
Record length: 41  
Use: Risk factors.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RISK	C	25	Primary key - risk factor (Allowable values determined locally.)
2	RISK_DW	D	8	Date written
3	RISK_TW	C	8	Time written

Table: **RXCODE.DBF**  
Type: Reference  
Record length: 46  
Use: Treatments.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RX	C	30	Primary key - treatment (Allowable values determined locally.)
2	DATEWRIT	D	8	Date written
3	TIMEWRIT	C	8	Time written

Table: **SIGNCODE.DBF**  
Type: Reference  
Record length: 37  
Use: Clinical sign.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	SIGN	C	20	Primary key - clinical sign (Allowable values determined locally.)
2	SEX	C	1	Code for sex-specific clinical sign 1 = Males only 2 = Females only 9 = Not sex-specific
3	SIGN_DW	D	8	Date written
4	SIGN_TW	C	8	Time written

Table: **SPECIMEN.DBF**  
 Type: Reference  
 Record length: 29  
 Use: Specimen collection sites.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	SPECIMEN	C	10	Primary key - specimen site (Allowable values determined locally.)
2	SEX	C	1	Code for sex-specific specimen site 1 = Male only 2 = Female only 9 = Not sex-specific
3	NETSS_CODE	C	2	NETSS translation code for specimen site 01 = Cervix 02 = Lesion-Genital 03 = Lesion-Extra Genital 04 = Lymph Node Aspirate 05 = Naso-Pharynx 06 = Ophthalmia/Conjunctiva 07 = Other 08 = Other Aspirate 09 = Rectum 10 = Urethra 11 = Urine 12 = Vagina 88 = Not Applicable 99 = Unknown
4	SPEC_DW	D	8	Date written
5	SPEC_TW	C	8	Time written

Table: **SYMPCODE.DBF**  
 Type: Reference  
 Record length: 32  
 Use: Symptoms.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	SYMPTOM	C	15	Primary key - symptom (Allowable values determined locally.)
2	SEX	C	1	Code for sex-specific symptom 1 = Male only 2 = Female only 9 = Not sex-specific
3	SYMP_DW	D	8	Date written
4	SYMP_TW	C	8	Time written

Table: **TESTTYPE.DBF**  
 Type: Reference  
 Record length: 33  
 Use: Lab test types.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	TEST_TYPE	C	10	Primary key - type of test (Allowable values determined locally.)
2	DISEASE	C	3	Disease detected by test. (See field DISEASE in table DXCODE for valid values.)
3	QUANTIFY	C	1	Quantifiable test? Y = Yes, test has quantitative results N = No, test does not have quantitative results
4	TITER	C	1	Quantitative results in titer format? Y = Yes, results are in titer format N = No, results are not in titer format
5	ENTER_SITE	C	1	Require entry of anatomical site of specimen? Y = Yes, specimen site required N = No, specimen site not required
6	MAKE_MORB	C	1	If test positive, allow creation of morbidity? Y = Yes, allow morbidity creation N = No, don't allow morbidity creation
7	DATEWRIT	D	8	Date written
8	TIMEWRIT	C	8	Time written

Table: **VREASON.DBF**  
 Type: Reference  
 Record length: 32  
 Use: Reason for clinic visit.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	REASON	C	15	Primary key - reason for visit (Allowable values determined locally.)
2	SEX	C	1	Code for sex-specific reason for visit 1 = Males only 2 = Females only 9 = Not sex-specific
3	REA_DW	D	8	Date written
4	REA_TW	C	8	Time written

Table: **WORKER.DBF**  
 Type: Reference  
 Record length: 40  
 Use: STD control workers.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	NAME	C	20	Worker name
2	WORKERNO	C	3	Primary key - worker number
3	TYPE	C	1	Type of worker C = Clerical D = DIS H = HIV field staff N = Nurse M = Manager S = Surveillance O = Other U = Unknown
4	DATEWRIT	D	8	Date written
5	TIMEWRIT	C	8	Time written

Table: **CSUPLD.DBF**  
 Type: Upload  
 Record length: 540  
 Use: Uploaded congenital syphilis records.

No.	Field	Type	Length	Comment
1	CS_ID	C	10	See table STD126.
2	SITE	C	2	Site where uploaded record originated (site codes are determined locally).
3	CASEID	C	10	See table STD126.
4	PATIENT_ID	C	10	See table STD126.
5	MOTHER_ID	C	10	See table STD126.
6	MORB_ID	C	10	See table STD126.
7	BABY_NAME	C	30	See table PATIENT.
8	MOM_NAME	C	30	See table PATIENT
9	MOM_DOB	D	8	See table PATIENT.
10	M_RACE	C	1	See table PATIENT.
11	M_MULT_RAC	C	1	See table PATIENT
12	M_ETHNIC	C	1	See table PATIENT.
13	I_SEX	C	1	See table PATIENT.
14	I_RACE	C	1	See table PATIENT.
15	I_MULT_RAC	C	1	See table PATIENT.
16	I_ETHNIC	C	1	See table PATIENT.
17	R_CITY	C	20	See table ADDRESS (mother-s address).
18	R_COUNTY	C	20	See table ADDRESS (mother-s address).
19	R_STATE	C	2	See table ADDRESS (mother-s address).
20	R_ZIP	C	5	See table ADDRESS (mother-s address).
21	R_COUNTRY	C	30	See table ADDRESS (mother's address).
22	M_CHART	C	10	See table STD126.
23	I_CHART	C	10	See table STD126.
24	DELIVER_MD	C	20	See table STD126.
25	MD_TYPE	C	2	See table STD126.
26	DEL_PHONE	C	12	See table STD126.
27	PEDIATRICI	C	20	See table STD126.
28	PED_PHONE	C	12	See table STD126.
29	LOCALID	C	7	See table STD126.
30	REPORT_DT	D	8	See table STD126.
31	STNAME	C	2	See table STD126.
22	CNTYNM	C	20	See table STD126.
33	CITYNM	C	20	See table STD126.
34	OTHERGEO	C	3	See table STD126.
35	SENTINEL	C	1	See table STD126.

**CSUPLD.DBF (cont.)**

36	MARITAL	C	1	See table STD126.
37	LMP_DT	D	8	See table STD126.
38	PRENATAL	C	1	See table STD126.
39	PNC_DT	D	8	See table STD126.
40	PNCNUM	N	2	See table STD126.
41	NONTREP	C	1	See table STD126.
42	TEST_A_DT	D	8	See table STD126.
43	RESULTA	C	1	See table STD126.
44	TITER_A	N	4	See table STD126.
45	TEST_B_DT	D	8	See table STD126.
46	RESULTB	C	1	See table STD126.
47	TITER_B	N	4	See table STD126.
48	TEST_C_DT	D	8	See table STD126.
49	RESULTC	C	1	See table STD126.
50	TITER_C	N	4	See table STD126.
51	TEST_D_DT	D	8	See table STD126.
52	RESULTD	C	1	See table STD126.
53	TITER_D	N	4	See table STD126.
54	TREPONEM	C	1	See table STD126.
55	LESIONS	C	1	See table STD126.
56	LASTREAT	C	1	See table STD126.
57	LAST_RX_DT	D	8	See table STD126.
58	TXADQBEF	C	1	See table STD126.
59	TXADQDUR	C	1	See table STD126.
60	RESPAPPR	C	1	See table STD126.
61	VITAL	C	1	See table STD126.
62	DEL_DATE	D	8	See table STD126.
63	DEATH_DT	D	8	See table STD126.
64	BIRTHWT	N	4	See table STD126.
65	AGE	N	2	See table STD126.
66	REACSTS	C	1	See table STD126.
67	REACT_DT	D	8	See table STD126.
68	INF_TITER	N	4	See table STD126.
69	REACT_TREP	C	1	See table STD126.
70	TREP_DT	D	8	See table STD126.
71	SIGNSCS	C	1	See table STD126.
72	DARKFLD	C	1	See table STD126.
73	DFA	C	1	See table STD126.
74	IGM	C	1	See table STD126.
75	XRAYS	C	1	See table STD126.
76	CSFVDRL	C	1	See table STD126.
77	CSFCOUNT	C	1	See table STD126.
78	TREATED	C	1	See table STD126.

**CSUPLD.DBF (cont.)**

79	CLASS	C	1	See table STD126.
80	VERSION	C	7	See table STD126.
81	CS_ENTRY	C	4	See table STD126.
82	STD_DW	D	8	See table STD126.
83	STD_TW	C	8	See table STD126.

Table: **FRUPLD.DBF**  
 Type: Upload  
 Record length: 302  
 Use: Uploaded field records.

No.	Field	Type	Length	Comment
1	FR_ID	C	10	See table FR.
2	DISEASE_NO	C	1	1 = 1 <sup>st</sup> disease on field record, 2 = 2 <sup>nd</sup> disease on field record
3	PATIENT_ID	C	10	See table FR.
4	FR_NO	C	8	See table FRA.
5	EVENT_ID	C	10	See table FR.
6	CASE_NO	C	10	See table REFERRAL
7	NAME	C	30	See table PATIENT or table SHORTFR.
8	AGE	N	3	See table FRA.
9	SEX	C	1	See table PATIENT or table SHORTFR.
10	RACE	C	1	See table PATIENT.
11	MULT_RACE	C	13	See table PATIENT.
12	RACE_TYPE	C	1	See table PATIENT.
13	ETHNICITY	C	1	See table PATIENT.
14	CITY	C	25	See table ADDRESS.
15	COUNTY	C	20	See table ADDRESS.
16	DISTRICT	C	2	See table ADDRESS.
17	STATE	C	2	See table ADDRESS.
18	ZIP	C	5	See table ADDRESS.
19	CENSUS_TR	C	5	See table ADDRESS.
20	PROV_FL	L	1	See table ADDRESS.
21	MARITAL_ST	C	1	See table FRA.
22	PREGNANT	C	1	See table FRA.
23	FR_PREG_WK	N	2	See table FRA
24	INIT_AGENCY	C	20	See table FRA.
25	LOC_INIT	C	1	See table FRA.
26	INVEST_AGN	C	20	See table FR.
27	LOC_INVEST	C	1	See table FR.
28	CLINIC_COD	C	8	See table FRA.
29	DISEASE	C	3	See table REFERRAL.
30	FIRST_EXP	D	8	See table FR.
31	FREQ_EXP	C	8	See table FR.
32	LAST_EXP	D	8	See table FR.
33	REF_BASIS	C	2	See table REFERRAL.
34	TYPE_REF	C	1	See table REFERRAL.
35	INTERVIEWR	C	3	See table REFERRAL.

**FRUPLD.DBF (cont.)**

36	INIT_DT	D	8	See table REFERRAL.
37	TYPE_IX	C	1	See table REFERRAL.
38	DISPO	C	1	See table FRB.
39	DISPO_DT	D	8	See table FRB.
40	WORKER	C	3	See table FRB.
41	NEW_CASENO	C	10	New case number if field record dispositioned as infected.
42	DIAGNOSIS	C	3	See table CASE.
43	SOURCE_SPR	C	1	See table FRB.
44	POST_CNLSL	C	1	See table FRB.
45	FR_ENTRY	C	4	See table FR.
46	FR_DW	D	8	See table FR.
47	FR_TW	C	8	See table FR.

Table: **HISTUPLD.DBF**  
 Type: Upload  
 Record length: 65  
 Use: Uploaded clinic diagnosis records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	HISTORY_ID	C	10	See table HISTORY
2	PATIENT_ID	C	10	See table HISTORY.
3	EVENT_ID	C	10	See table HISTORY.
4	DISEASE	C	3	See table HISTORY.
5	DIAGNOSIS	C	3	See table HISTORY.
6	CURRENT	C	1	See table HISTORY.
7	DATE_PREV	C	8	See table HISTORY.
8	HIS_ENTRY	C	4	See table HISTORY.
9	HIS_DW	D	8	See table HISTORY.
10	HIS_TW	C	8	See table HISTORY.

Table: **IRUPLD.DBF**  
 Type: Upload  
 Record length: 368  
 Use: Uploaded interview records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	IRB_ID	C	11	See table IRB.
2	IX_ID	C	10	See table IRA.
3	PATIENT_ID	C	10	See table PATIENT.
4	EVENT_ID	C	10	See table IRA.
5	CONTROL_NO	C	10	See table IRA.
6	CASE_NO	C	10	See table CASE.
7	INFORM_ID	C	10	See table IRB.
8	NAME	C	30	See table PATIENT.
9	SEX	C	1	See table PATIENT.
10	RACE	C	1	See table PATIENT.
11	MULT_RACE	C	13	See table PATIENT.
12	RACE_TYPE	C	1	See table PATIENT.
13	ETHNICITY	C	1	See table PATIENT.
14	CITY	C	25	See table ADDRESS.
15	COUNTY	C	20	See table ADDRESS.
16	DISTRICT	C	2	See table ADDRESS.
17	STATE	C	2	See table ADDRESS.
18	ZIP	C	5	See table ADDRESS.
19	CENSUS_TR	C	5	See table ADDRESS.
20	PROV_FL	L	1	See table ADDRESS.
21	AGE	N	3	See table IRA.
22	PREGNANT	C	1	See table IRA.
23	PREG_WKS	N	2	See table IRA.
24	IR_BIRTH	C	1	See table IRA.
25	DIAGNOSIS	C	3	See table CASE.
26	NEURO	C	1	See table CASE.
27	CAS_DETECT	C	2	See table CASE.
28	CONTACT_TO	C	3	See table CASE.
29	PROVIDER	C	20	See table CASE.
30	PROV_TYPE	C	2	See table CASE.
31	DX_DATE	D	8	See table CASE.
32	SUPV_NO	C	3	See table IRA.
33	CLINIC_COD	C	8	See table IRA.
34	MED_REC_NO	C	10	See table IRA.
35	PRE_CNSL	C	1	See table IRA.
36	POST_CNSL	C	1	See table IRA.
37	HIV_TEST	C	1	See table IRA.

**IRUPLD.DBF (cont.)**

38	PRE_HIV	C	1	See table IRA.
39	PRE_HIV_DT	D	8	See table IRA.
40	PRE_CODE	C	2	See table IRA.
41	PRE_NAME	C	20	See table IRA.
42	CUR_HIV	C	1	See table IRA.
43	CUR_HIV_DT	D	8	See table IRA.
44	CUR_CODE	C	2	See table IRA.
45	CUR_NAME	C	20	See table IRA.
46	OTH_INF_1	C	3	See table IRA.
47	OTH_INF_2	C	3	See table IRA.
48	ASSIGN_DT	D	8	See table IRB.
49	ASSIGN_TO	C	3	See table IRB.
50	CASE_IX	C	1	See table IRB.
51	IX_PERIOD	N	2	See table IRB.
52	SEX_PART	N	3	See table IRB.
53	NS_PART	N	3	See table IRB.
54	BOTH_PART	N	3	See table IRB.
55	GEND_PART	C	1	See table IRA.
56	CLOSED_DT	D	8	See table IRB.
57	IR_ENTRY	C	4	See table IRA.
58	IR_DW	D	8	See table IRA.
59	IR_TW	C	8	See table IRA.

Table: **MORBUPLD.DBF**  
 Type: Upload  
 Record length: 264  
 Use: Uploaded morbidity records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	MORB_ID	C	10	See table MORBREPT.
2	PATIENT_ID	C	10	See table MORBREPT.
3	EVENT_ID	C	10	See table MORBREPT.
4	NAME	C	30	See table PATIENT.
5	DOB	D	8	See table PATIENT.
6	SEX	C	1	See table PATIENT.
7	RACE	C	1	See table PATIENT.
8	MULT_RACE	C	13	See table PATIENT.
9	RACE_TYPE	C	1	See table PATIENT.
10	ETHNICITY	C	1	See table PATIENT.
11	CITY	C	25	See table ADDRESS.
12	COUNTY	C	20	See table ADDRESS.
13	DISTRICT	C	2	See table ADDRESS.
14	STATE	C	2	See table ADDRESS.
15	ZIP	C	5	See table ADDRESS.
16	CENSUS_TR	C	5	See table ADDRESS.
17	COUNTRY	C	30	See table ADDRESS.
18	PROV_FL	L	1	See table ADDRESS.
19	CASE_NO	C	10	See table CASE.
20	DISEASE	C	3	See table CASE.
21	DIAGNOSIS	C	3	See table CASE.
22	PID	C	1	See table CASE.
23	NEURO	C	1	See table CASE.
24	CAS_DETECT	C	2	See table CASE.
25	PROVIDER	C	20	See table CASE.
26	PROV_TYPE	C	2	See table CASE.
27	DX_DATE	D	8	See table CASE.
28	IMPORTED	C	1	See table CASE.
29	ORIGIN	C	1	See table MORBREPT.
30	MMWR_WEEK	C	2	See table MORBREPT.
31	MMWR_YEAR	C	2	See table MORBREPT.
32	REPT_DT	D	8	See table MORBREPT.
33	PREGNANT	C	1	See table MORBREPT.
34	MORB_AGE	N	3	See table MORBREPT.
35	NAMED	L	1	See table MORBREPT.
36	MORB_ENTRY	C	4	See table MORBREPT.
37	MORB_DW	D	8	See table MORBREPT.

**MORBUPLD.DBF (cont.)**

38	MORB_TW	C	8	See table MORBREPT.
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Table: **PATUPLD.DBF**  
 Type: Upload  
 Record length: 318  
 Use: Template for creating patient upload file.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	PATIENT_ID	C	10	See table PATIENT.
2	LAST_NAME	C	20	See table PATIENT.
3	FIRST_NAME	C	20	See table PATIENT.
4	M_INITIAL	C	1	See table PATIENT.
5	F_L_SNDX	C	8	See table PATIENT.
6	F_SNDX	C	4	See table PATIENT.
7	DOB	D	8	See table PATIENT.
8	SSN	C	11	See table PATIENT.
9	SEX	C	1	See table PATIENT.
10	RACE	C	1	See table PATIENT.
11	MULT_RACE	C	13	See table PATIENT.
12	RACE_TYPE	C	1	See table PATIENT.
13	ETHNICITY	C	1	See table PATIENT.
14	MED_REC_NO	C	10	See table PATIENT.
15	HARS_ID	C	10	See table PATIENT.
16	ARCHIVE	L	1	See table PATIENT.
17	NAMED	L	1	See table PATIENT.
18	TEMP_DOB	D	8	See table PATIENT.
19	PAT_ENTRY	C	4	See table PATIENT.
20	PAT_DW	D	8	See table PATIENT.
21	PAT_TW	C	8	See table PATIENT.
22	ADDRESS_ID	C	10	See table ADDRESS.
23	AS_OF	D	8	See table ADDRESS.
24	STREET_1	C	30	See table ADDRESS.
25	CITY	C	25	See table ADDRESS.
26	COUNTY	C	20	See table ADDRESS.
27	DISTRICT	C	2	See table ADDRESS.
28	STATE	C	2	See table ADDRESS.
29	ZIP	C	5	See table ADDRESS.
30	CENSUS_TR	C	8	See table ADDRESS.
31	COUNTRY	C	30	See table ADDRESS.
32	HOME_PHONE	C	12	See table ADDRESS.
33	PROV_FL	L	1	See table ADDRESS.
34	ADD_DW	D	8	See table ADDRESS.
35	ADD_TW	C	8	See table ADDRESS.

Table: **RISKUPLD.DBF**  
Type: Upload  
Record length: 65  
Use: Uploaded risk factor records.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RISK_ID	C	10	See table RISK.
2	PATIENT_ID	C	10	See table RISK.
3	EVENT_ID	C	10	See table RISK.
4	RISK	C	25	See table RISK.
5	RISK_ENTRY	C	4	See table RISK.
6	RIS_DW	D	8	See table RISK.
7	RIS_TW	C	8	See table RISK.

Table: **RXUPLD.DBF**  
Type: Upload  
Record length: 100  
Use: Uploaded treatment records.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	RX_ID	C	10	See table RX.
2	PATIENT_ID	C	10	See table RX.
3	EVENT_ID	C	10	See table RX.
4	RX	C	30	See table RX.
5	PROVIDER	C	20	See table RX.
6	RX_ENTRY	C	4	See table RX.
7	RX_DW	D	8	See table RX.
8	RX_TW	C	8	See table RX.

Table: **SIGNUPLD.DBF**  
Type: Upload  
Record length: 79  
Use: Uploaded clinical signs records.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	SIGNS_ID	C	20	See table SIGNS.
2	PATIENT_ID	C	10	See table SIGNS.
3	EVENT_ID	C	10	See table SIGNS.
4	SIGNS	C	20	See table SIGNS.
5	SIGN_ENTRY	C	3	See table SIGNS.
6	SIGNS_DW	D	8	See table SIGNS.
7	SIGNS_TW	C	8	See table SIGNS.

Table: **SYMPUPLD.DBF**  
 Type: Upload  
 Record length: 77  
 Use: Uploaded symptoms records.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	SYMPTOM_ID	C	10	See table SYMPTOMS.
2	PATIENT_ID	C	10	See table SYMPTOMS.
3	EVENT_ID	C	10	See table SYMPTOMS.
4	ONSET_DT	D	8	See table SYMPTOMS.
5	DURATION	N	4	See table SYMPTOMS.
6	SYM_DESCR	C	15	See table SYMPTOMS.
7	SYM_ENTRY	C	4	See table SYMPTOMS.
8	SYM_DW	D	8	See table SYMPTOMS.
9	SYM_TW	C	8	See table SYMPTOMS.

Table: **TESTUPLD.DBF**  
 Type: Upload  
 Record length: 304  
 Use: Uploaded lab test records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	TEST_ID	C	10	See table TEST.
2	PATIENT_ID	C	10	See table TEST.
3	REACTOR_ID	C	10	See table TEST.
4	EVENT_ID	C	10	See table TEST.
5	NAME	C	30	See table PATIENT.
6	SEX	C	1	See table PATIENT.
7	RACE	C	1	See table PATIENT.
8	MULT_RACE	C	13	See table PATIENT.
9	RACE_TYPE	C	1	See table PATIENT.
10	ETHNICITY	C	1	See table PATIENT.
11	CITY	C	25	See table ADDRESS.
12	COUNTY	C	20	See table ADDRESS.
13	DISTRICT	C	2	See table ADDRESS.
14	STATE	C	2	See table ADDRESS.
15	ZIP	C	5	See table ADDRESS.
16	CENSUS_TR	C	5	See table ADDRESS.
17	PROV_FL	L	1	See table ADDRESS.
18	AGE	N	3	See table TEST.
19	RECEIVE_DT	D	8	See table TEST.
20	RECEIVE_BY	C	3	See table REACTOR.
21	PRIORITY	C	15	See table REACTOR.
22	LAB	C	20	See table TEST.
23	PROVIDER	C	20	See table TEST.
24	PROV_TYPE	C	2	See table TEST.
25	COLLECT_DT	D	8	See table TEST.
26	TEST_DATE	D	8	See table TEST.
27	TEST_TYPE	C	10	See table TEST.
28	TEST_SITE	C	10	See table TEST.
29	TEST_DISEA	C	3	See table TEST.
30	QUAL_RESUL	C	1	See table TEST.
31	QUAN_RESUL	C	8	See table TEST.
32	NAMED	L	1	See table TEST.
33	SURV_DISPO	C	1	See table SURVCLOS.
34	FLD_DISPO	C	1	See table FRB.
35	ACCESS_NO	C	15	See table TEST.
36	TEST_ENTRY	C	4	See table TEST.
37	TEST_DW	D	8	See table TEST.

**TESTUPLD.DBF (cont.)**

38	TEST_TW	C	8	See table TEST.
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**Table: UPLDLINK.DBF**  
**Type: Upload**  
**Record length: 56**  
**Use: Link between uploaded and local patient records.**

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	LOCAL_ID	C	10	Foreign key - local system generated patient id
2	REMOTE_ID	C	10	Foreign key - remote system generated system id
3	LOC_ADD_ID	C	10	Foreign key - local system generated address id
4	REM_ADD_ID	C	10	Foreign key - remote system generated address id
5	UPLD_DW	D	8	Date written
6	UPLD_TW	C	8	Time written

Table: **VISUPLD.DBF**  
 Type: Upload  
 Record length: 238  
 Use: Uploaded clinic visit records.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	VISIT_ID	C	10	See table VISIT.
2	PATIENT_ID	C	10	See table VISIT.
3	EVENT_ID	C	10	See table VISIT.
4	NAME	C	30	See table PATIENT.
5	DOB	D	8	See table PATIENT.
6	AGE	N	3	See table PATIENT.
7	SEX	C	1	See table PATIENT.
8	RACE	C	1	See table PATIENT.
9	MULT_RACE	C	13	See table PATIENT.
10	RACE_TYPE	C	1	See table PATIENT.
11	ETHNICITY	C	1	See table PATIENT.
12	CITY	C	25	See table ADDRESS.
13	COUNTY	C	20	See table ADDRESS.
14	DISTRICT	C	2	See table ADDRESS.
15	STATE	C	2	See table ADDRESS.
16	ZIP	C	5	See table ADDRESS.
17	CENSUS_TR	C	5	See table ADDRESS.
18	VISIT_DT	D	8	See table VISIT.
19	REASON	C	15	See table VISIT.
20	CLINIC	C	20	See table VISIT.
21	CLINIC_TYP	C	2	See table VISIT.
22	CLINICIAN	C	20	See table VISIT.
23	INSURANCE	C	1	See table VISIT.
24	PREGNANT	C	1	See table VISIT.
25	INFERTILE	C	1	See table VISIT.
26	PRE_CNSL	C	1	See table VISIT.
27	POST_CNSL	C	1	See table VISIT.
28	NAMED	L	1	See table VISIT.
29	VIS_ENTRY	C	4	See table VISIT.
30	VIS_DW	D	8	See table VISIT.
31	VIS_TW	C	8	See table VISIT.

Table: **ASCIIDEF.DBF**  
 Type: Other  
 Record length: 522  
 Use: Contains definitions for lab and morbidity ASCII imports.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	A_ASCII	C	10	Type of import - MORBIDITY or LAB TESTS
2	A_TITLE	C	15	Title of import (user-defined/modifiable)
3	A_FILE	C	10	Data Element Destination table in STD*MIS
4	A_FIELD	C	10	Data Element Destination field in STD*MIS
5	A_SEQ	C	4	Display sequence in definition browse
6	A_TYPE	C	1	DBF Field type
7	A_LEN	N	4	DBF Field length
8	A_DEC	N	2	DBF Number of decimal places
9	A_START	N	4	Starting column definition in import file
10	A_END	N	4	Ending column definition in import file
11	A_PRE_BLK	C	150	Code block for pre-processing field data
12	A_POST_BLK	C	150	Code block for post-processing field data
13	A_USABLE	L	1	Is Field visible to user (i.e. hides ID fields, etc.)
14	A_DEF_VAL	C	1	Data Definition Requirement Type (D,V,I,B,A) D-Defined: User must define field (offsets) V-Value: Non-blank value required of datum I-Ignore: Blank Value Causes record skip B-Both: User must define & Value Required A-All: User must define & Blanks cause skip NOTE: This value is set programmatically
15	A_PRE_T	C	1	Pre-Block Type [B)efore, 1)st time, E)ach time] B-Block is evaluated before import begins; value is then used throughout import. 1-Block evaluated upon 1 <sup>st</sup> occurrence, in 1 <sup>st</sup> record encountered; value is then used through rest of import. E-Block is evaluated for each import record
16	A_POST_T	C	1	Post-Block Type [B)efore, 1)st time, E)ach]
17	A_SKIP_BLK	C	150	Code block used for skipping certain records (Currently, no import process uses this field.)
18	A_LEN_MIN	N	2	Minimum definable length of field in ASCII file
19	A_LEN_MAX	N	2	Maximum definable length of fld in ASCII file

Table: **ASCIIMST.DBF**  
 Type: Other  
 Record length: 1495  
 Use: Master file for Ascii imports.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	M_TYPE	C	10	Type of import - MORBIDITY or LAB TESTS
2	M_TITLE	C	15	Title of ASCII import
3	M_DRIVE	C	1	Drive where ASCII import file resides
4	M_PATH	C	50	Directory where ASCII import file resides
5	M_FILE	C	12	Name of ASCII import file
6	M_DATE	D	8	Date definition created
7	M_TIME	C	8	Time definition created
8	M_FILES	C	150	String of Std*Mis tables updated during import
9	M_EXACT	C	150	Code block for exact fields matching function
10	M_XREFS	C	150	Cross-reference file/fields definition string
11	M_NEARFLDS	C	150	Fields used in determining close patient matches
12	M_NEARDEFS	C	150	Criteria string for determining patient matches
13	M_DX_ANON	C	250	String of DX codes for Non-named status
14	M_RESULTS	L	1	Flag to use results w/DX codes (in m_dx_anon)
15	M_INTERIM	L	1	Flag used to allow Interim process (Lab only)
16	M_DX_OUT	C	250	string of DX codes and Outcomes
17	M_PROC_BLK	C	100	Interim Process Code Block (Lab use only)
18	M_ACTIVE	L	1	Flag to show/hide definition from user
19	M_LAB	C	20	Source laboratory of lab import file
20	M_IDATE	D	8	Date of last successful import
21	M_ITIME	C	10	Time of last successful import

**Table:** **ASCIIXRE.DBF**  
**Type:** Other  
**Record length:** 156  
**Use:** Ascii import cross-reference table of updatable values used in translation incoming data

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	Y_ASCII	C	10	Type of import - MORBIDITY or LAB TESTS
2	Y_TITLE	C	15	Title of import
3	Y_FILE	C	10	Data Element Destination table in STD*MIS
4	Y_FIELD	C	10	Data Element Destination field in STD*MIS
5	Y_OURS	C	35	Lookup value of field in STD*MIS
6	Y_THEIRS	C	35	Corresponding value from ASCII import file
7	Y_DEFAULT	L	1	Is this the default value for this field?
8	Y_CUSTOM	C	40	Custom Value Code Block (not used (9/99))

**Table:** **ASCIIXRF.DBF**  
**Type:** Other  
**Record length:** 116  
**Use:** Ascii import cross-reference table of static values used in  
translation  
incoming data

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	X_ASCII	C	10	Type of import - MORBIDITY or LAB TESTS
2	X_TITLE	C	15	Title of import
3	X_FILE	C	10	Data Element Destination table in STD*MIS
4	X_FIELD	C	10	Data Element Destination field in STD*MIS
5	X_OURS	C	35	Lookup value of field in STD*MIS
6	X_THEIRS	C	35	Corresponding value from ASCII import file
7	X_DEFAULT	L	1	Is this the default value for this field?

Table: **CSDATE.DBF**  
Type: Other  
Record length: 16  
Use: Pass date parameters to EpiInfo congenital syphilis reports.

No.	Field	Type	Length	Comment
1	BEGIN	D	8	Beginning report date.
2	END	D	8	Ending report date.

Table: **CURRENT.DBF**  
 Type: Other  
 Record length: 67  
 Use: Hold current information about system files and reports.

No.	Field	Type	Length	Comment
1	TYPE	C	1	See table REPTMENU
2	NAME	C	8	Name of file
3	EXTENSION	C	3	File extension
4	DESCRIP	C	30	Text description of file
5	STANDALONE	C	1	Y = Standalone .exe N = Input file to external report generator
6	COMMAND	C	8	If not standalone, command to start report generator
7	FILE_DATE	C	10	Date of most current version of file
8	FILE_TIME	C	5	Time of most current version of file
9	REPT	C	1	Y = Update REPTMENU if needed N = Ignore REPTMENU updating

Table: **DUPEDATE.DBF**  
Type: Other  
Record length: 8  
Use: Date last duplicate patient report run.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	CHK_DATE	D	8	Date last duplicate patient report run

Table: **DUPELIST.DBF**  
Type: Other  
Record length: 21  
Use: Duplicate patient pairs to be processed.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	KEY_1	C	10	1st patient id of duplicate pair
2	KEY_2	C	10	2nd patient id of duplicate pair
3	EXACT	L	1	Is pair an exact match?

Table: **DUPEPAT.DBF**  
Type: Other  
Record length: 60  
Use: Patient records to be duplicate checked.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	PATIENT_ID	C	10	Primary key - system generated patient id
2	LAST_NAME	C	20	
3	FIRST_NAME	C	20	
4	DOB	D	8	Date of birth
5	SEX	C	1	(See field SEX in table PATIENT for valid codes.)
6	RACE	C	1	(See field RACE in table PATIENT for valid codes.)

Table: **EXTRACTS.DBF**  
 Type: Other  
 Record length: 49  
 Use: Save user-defined analysis extracts.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	E_EXTRACT	C	10	Unique extract title name
2	E_USER	C	8	User id of person defining extract
3	E_FILE	C	10	STD*MIS file name
4	E_FIELD	C	10	STD*MIS field name
5	E_SEQ	C	4	Field order sequence number
6	E_TYPE	C	1	STD*MIS field type
7	E_LEN	N	4	STD*MIS field length
8	E_DEC	N	2	STD*MIS field decimal length

Table: **FILELIST.DBF**  
 Type: Other  
 Record length: 83  
 Use: Master list of all data and index files in the system.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	MASTER	C	8	Name of data file
2	ORDER	C	2	Index order
3	NAME	C	12	Full DOS file name including extension
4	TYPE	C	1	Type of file: D = Data file I = Index file R = Reference file S = System file
5	KEY	C	60	Index key (not used)

Table: **HELPTEXT.DBF**  
Type: Other  
Record length: 40  
Use: Online help text.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	FUNC_NAME	C	10	Primary key - function name
2	DESCRIP	C	20	Description of function
3	SCREEN	M	10	Help screen text

Table: **LOCLLIST.DBF**  
 Type: Other  
 Record length: 229  
 Use: List of active and inactive local use files.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	MASTER	C	8	
2	ORDER	C	2	
3	DRIVE	C	1	Drive where file resides.
4	PATH	C	80	Directory where file resides.
5	NAME	C	8	Name of local use file.
6	INDX	C	8	Name of index for local use file
7	TYPE	C	1	
8	KEY	C	60	
9	MENULABEL	C	30	Descriptive name of file.
10	UNDERCODE	C	8	Name of default Std*Mis local use file this file is associated with.
11	ACTIVE	L	1	Active/Inactive switch
12	LOC_DW	D	8	Date file created.
13	LOC_TW	C	10	Time file created.
14	LOC_ENTRY	C	4	Creator of new file

**Table: LOCLLOOK.DBF**  
**Type: Other**  
**Record length: 139**  
**Use: List of data entry edits and screen prompts for local use fields.**

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	L_FILE	C	10	Name of local use file field is associated with.
2	L_FIELD	C	10	Name of local use field.
3	L_TYPE	C	10	
4	L_WIDTH	N	2	
5	L_KIND	C	1	
6	L_VALUE	C	35	
7	L_LOOKUP	C	35	
8	L_DEFAULT	L	1	
9	L_PROMPT	C	35	Onscreen data entry prompt.

Table: **MERGHOLD.DBF**  
Type: Other  
Record length: 36  
Use: Patient records selected to be merged.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	KEEP_ID	C	10	Patient id of patient record to be kept
2	TOSS_ID	C	10	Patient id of patient record to be discarded
3	MERGE_DW	D	8	Date written
4	MERGE_TW	C	8	Time written

Table: **MMWRYEAR.DBF**  
 Type: Other  
 Record length: 29  
 Use: Offset values to use when calculating CDC Morbidity and Mortality Weekly Report (MMWR) week and year values.

No.	Field	Type	Length	Comment
1	MMWR_YEAR	C	4	Primary key - MMWR year
2	MMWR_START	D	8	Calendar date MMWR year begins on
3	ADJUST	N	1	Number of days between start of MMWR year and start of calendar year
4	DATEWRIT	D	8	Date written
5	TIMEWRIT	C	8	Time written

Table: **MORBDATE.DBF**  
Type: Other  
Record length: 16  
Use: Pass date parameters to EpiInfo morbidity reports.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	BEGIN	D	8	Beginning report date.
2	END	D	8	Ending report date.

Table: **MORBPEND.DBF**  
Type: Other  
Record length: 36  
Use: Positive lab tests awaiting confirming provider report.

No.	Field	Type	Length	Comment
1	PATIENT_ID	C	10	Foreign key - system generated patient id
2	EVENT_ID	C	10	Foreign key - system generated event id
3	PEND_DW	D	8	Date written
4	PEND_TW	C	8	Time written

Table: **PATCHES.DBF**  
Type: Other  
Record length: 33  
Use: List of CDC-supplied data correction programs.

No.	Field	Type	Length	Comment
1	PROGRAM	C	8	Name of program.
2	DESCRIP	C	25	Descriptive label of program.

Table: **REPTMENU.DBF**  
 Type: Other  
 Record length: 51  
 Use: Master report list.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	TYPE	C	1	Type of report: C = Congenital syphilis L = Laboratory reports M = Morbidity O = Other reports Q = Quality assurance T = Tracking U = Database utility reports V = Clinic visit W = Worker activity reports
2	NAME	C	8	Name of report
3	EXTENSION	C	3	File extension of report file
4	DESCRIP	C	30	Description of report
5	STANDALONE	C	1	Is report a standalone executable? Y = Yes, is standalone N = No, is not standalone
6	COMMAND	C	8	Command to start report program for non-standalone reports

Table: **STDSYS.DBF**  
 Type: Other  
 Record length: 151  
 Use: System configuration file.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	STATE	C	2	State code where system installed
2	SITE	C	2	Site code where system installed within the state
3	PATIENT_ID	N	8	Counter for system generated patient id numbers
4	TEST_ID	N	8	Counter for system generated test id numbers
5	VISIT_ID	N	8	Counter for system generated clinic visit id numbers
6	SHORT_ID	N	8	Counter for system generated interview-only field record numbers
7	MORB_ID	N	8	Counter for system generated morbidity id numbers
8	ADDRESS_ID	N	8	Counter for system generated address id numbers
9	REACT_ID	N	8	Counter for system generated reactor id numbers
10	CASE_NO	N	8	Counter for system generated case numbers
11	IX_ID	N	8	Counter for system generated interview id numbers
12	FR_ID	N	8	Counter for system generated field record id numbers
13	EVENT_ID	N	8	Counter for system generated STD event id numbers
14	OOJ_ID	N	8	Counter for system generated OOJ log id numbers
15	SYMPTOM_ID	N	8	Counter for system generated symptom record id numbers
16	RX_ID	N	8	Counter for system generated treatment id numbers
17	RISK_ID	N	8	Counter for system generated risk factor id numbers
18	SIGNS_ID	N	8	Counter for system generated clinical signs id numbers
19	HISTORY_ID	N	8	Counter for system generated clinic diagnoses id numbers
20	CS_ID	N	8	Counter for system generated congenital syphilis id numbers
21	DB_VERSION	C	3	Current version number of database.

Table: **TRANSMIT.DBF**  
 Type: Other  
 Record length: 9  
 Use: Last transmission date for various transmission types.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	TRANSTYPE	C	1	Type of transmission file built N = NETSS E = STD*MIS data transfer C = Chlamydia/GC infertility upload
2	TRANSDATE	D	8	Date transmission file built

Table: **USERS.DBF**  
 Type: Other  
 Record length: 93  
 Use: Valid user login id-s and passwords.

No.	Field	Type	Length	Comment
----	-----	----	-----	-----
1	USER_ID	C	8	Primary key - user id
2	NAME	C	25	User name
3	PW	C	6	User password
4	RIGHTS	C	1	User security rights: R = Read only E = Data entry L = Lead data entry operator A = System administrator
5	PW_DATE	D	8	Date password last changed
6	REF_DIR	C	25	Directory where local reference files are stored
7	LOGIN_CNT	N	2	Number of times user currently logged in.
8	MAX_LOGIN	N	2	Max. number of times a user is allowed to login.
9	DATEWRIT	D	8	Date written
10	TIMEWRIT	C	8	Time written

Table: **WSCONFIG.DBF**  
 Type: Other  
 Record length: 93  
 Use: Local workstation parameters.

No.	Field	Type	Length	Comment
----	-----	-----	-----	-----
1	SETTING	C	15	Type of setting: FONT SASPATH DOSPATH
2	VALUE	C	50	Value of setting.

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DATA TABLES

Table -----	Index -----	Order -----	Expression -----
ADDRESS	ADD01.CDX	1	ADDRESS_ID
		2	PATIENT_ID + dtos(AS_OF) for not PROV_FL
		3	HOME_PHONE
		4	PATIENT_ID
AKA	AKA01.CDX	1	PATIENT_ID
		2	AKA
		3	AKA_SNDX
ARCHIVE	ARC01.CDX	1	PATIENT_ID
CASE	CAS01.CDX	1	CASE_NO
		2	FRB_ID
		3	MORB_ID
		4	IRB_ID
EVENT	EVE01.CDX	1	EVENT_ID
FR	FR01.CDX	1	PATIENT_ID + ADDRESS_ID
		2	FR_ID
		3	EVENT_ID
		4	FR_DW FOR .NOT. EMPTY(SHORT_ID)
FRA	FRA01.CDX	1	FR_ID
		2	FR_NO
FRB	FRB01.CDX	1	FRB_ID
		2	DISPO_DT
FUPLOG	FUP01.CDX	1	REACTOR_ID
		2	MORB_ID
		3	PATIENT_ID
		4	EVENT_ID
		5	STATUS

Table -----	Index -----	Order -----	Expression -----
F_LOCAL	F_L01.CDX	1	FR_ID
HISTORY	HIS01.CDX	1	EVENT_ID
		2	HISTORY_ID
		3	PATIENT_ID
HOLD	HOL01.CDX	1	MORB_ID
		2	OOJ_ID
		3	REACTOR_ID
		4	IX_ID
IRA	IRA01.CDX	1	EVENT_ID
		2	PATIENT_ID
		3	CONTROL_NO
		4	IX_ID
IRB	IRB01.CDX	1	PATIENT_ID
		2	IRB_ID
		3	ASSIGN_DT
		4	CLOSED_DT
I_LOCAL	I_L01.CDX	1	IX_ID
MORBPEND	MOP01.CDX	1	PATIENT_ID
		2	EVENT_ID
MORBREPT	MOR01.CDX	1	PATIENT_ID + ADDRESS_ID
		2	PATIENT_ID for .not. NAMED
		3	EVENT_ID
		4	MORB_ID
		5	REPT_DT
		6	MMWR_YEAR
M_LOCAL	M_L01.CDX	1	MORB_ID
NOTES	NOT01.CDX	1	PATIENT_ID + EVENT_ID
		2	EVENT_ID
OOJLOG	OOJ01.CDX	1	PATIENT_ID + ADDRESS_ID
		2	OOJ_ID
		3	STATUS

Table	Index	Order	Expression
-----	-----	-----	-----
PATIENT	PAT01.CDX	1	PATIENT_ID
		2	left(LAST_NAME, 4) +
			left(FIRST_NAME, 1) for NAMED
		3	F_L_SNDX
		4	left(FIRST_NAME, 3) + for NAMED
		5	F_SNDX
		6	PAT_DW
	7	DOB	
PLINK	P_L01.CDX	1	PATIENT_ID
		2	REL_ID
REACTOR	REA01.CDX	1	REACTOR_ID
		2	PATIENT_ID
REFERRAL	REF01.CDX	1	FR_ID + DISEASE_NO
		2	CASE_NO
		3	REACTOR_ID
		4	OOJ_ID
		5	INIT_DT
REMOTE	REM01.CDX	1	PATIENT_ID + REC_TYPE +
		2	dtos(EVENT_DT) PATIENT_ID + SITE
REVIEW	REV01.CDX	1	PATIENT_ID
RISK	RIS01.CDX	1	EVENT_ID
		2	RISK_ID
		3	PATIENT_ID
RX	RX01.CDX	1	PATIENT_ID
		2	EVENT_ID
		3	RX_ID
R_LOCAL	R_L01.CDX	1	RX_ID
SHORTFR	SHO01.CDX	1	SHORT_ID

Table	Index	Order	Expression
-----	-----	-----	-----
SIGNS	SIG01.CDX	1	EVENT_ID
		2	SIGNS_ID
		3	PATIENT_ID
STD126	STD01.CDX	1	CASEID
		2	PATIENT_ID + ADDRESS_ID
		3	MOTHER_ID + MOM_ADD_ID
		4	REPORT_DT
		5	MORB_ID
		6	CS_ID
SURVCLOS	SUR01.CDX	1	REACTOR_ID
		2	MORB_ID
SYMPTOMS	SYM01.CDX	1	EVENT_ID
		2	SYMPTOM_ID
		3	PATIENT_ID
TEST	TES01.CDX	1	PATIENT_ID + ADDRESS_ID
		2	EVENT_ID
		3	TEST_ID for .not. NAMED
		4	REACTOR_ID
		5	TEST_ID
		6	COLLECT_DT
T_LOCAL	T_L01.CDX	1	TEST_ID
VISIT	VIS01.CDX	1	VISIT_ID
		2	PATIENT_ID + ADDRESS_ID
		3	VISIT_DT
		4	PATIENT_ID for .not. NAMED
V_LOCAL	V_L01.CDX	1	VISIT_ID

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REFERENCE TABLES

Table -----	Index -----	Order -----	Expression -----
AGENCY	AGE01.CDX	1	AGENCY
CLINICMD	CLI01.CDX	1	NAME
DXCODE	DXC01.CDX	1	DIAGNOSIS for DIAGNOSIS <> >700'
		2	DIAGNOSIS for DISEASE <> >700'
		3	DIAGNOSIS
GEO_AREA	GEO01.CDX	1	CITY unique
		2	CITY
		3	COUNTY unique
		4	ZIPCODE
		5	ZIPCODE unique
		6	COUNTY
		7	STATE unique
		8	CITY + COUNTY unique
		9	COUNTRY unique
LABCODE	LABCODE1.CDX	1	LAB
PRIORITY	PRIOR1.CDX	1	PRIORITY
PROVIDER	PROCODE1.CDX	1	PROVIDER
RISKCODE	RISCODE1.CDX	1	RISK
RXCODE	RXCODE1.CDX	1	RX
SIGNCODE	SIGCODE1.CDX	1	SIGN
SPECIMEN	SPEC01.CDX	1	SPECIMEN
SYMPCODE	SYMCODE1.CDX	1	SYMPTOM
TESTTYPE	TTYPER01.CDX	1	TEST_TYPE

VREASON	VRE01.CDX	1	REASON
WORKER	WORKER01.CDX	1	WORKERNO

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UPLOAD TABLES

Table -----	Index -----	Order -----	Expression -----
CSUPLD	CUP01.CDX	1	REPORT_DT
		2	SITE + CASEID
		3	MORB_ID
		4	CS_ID
FRUPLD	FRU01.CDX	1	FR_ID + DISEASE_NO
		2	INIT_DT
		3	CASE_NO
HISTUPLD	HIU01.CDX	1	HISTORY_ID
		2	EVENT_ID
IRUPLD	IRU01.CDX	1	IRB_ID
		2	ASSIGN_DT
		3	CASE_NO
		4	EVENT_ID
		5	PATIENT_ID
MORBUPLD	MUP01.CDX	1	REPT_DT
		2	MORB_ID
		3	PATIENT_ID
		4	MMWR_YEAR
		5	EVENT_ID
		6	CASE_NO
RISKUPLD	RIU01.CDX	1	RISK_ID
		2	EVENT_ID
RXUPLD	RXU01.CDX	1	RX_ID
		2	EVENT_ID
SIGNUPLD	SIU01.CDX	1	SIGNS_ID
		2	EVENT_ID
SYMPUPLD	SYU01.CDX	1	SYMPTOM_ID
		2	EVENT_ID

Table -----	Index -----	Order -----	Expression -----
TESTUPLD	TUP01.CDX	1	TEST_ID
		2	COLLECT_DT
		3	EVENT_ID
UPLDLINK	UPL01.CDX	1	REMOTE_ID
		2	LOCAL_ID
		3	UPLD_DW
VISUPLD	VUP01.CDX	1	VISIT_ID
		2	VISIT_DT
		3	PATIENT_ID

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SYSTEM/OTHER TABLES

Table -----	Index -----	Order -----	Expression -----
ASCIIDEF	ASC01.CDX	1	A_ASCII + A_TITLE + A_FILE + A_FIELD
ASCIIXRF	ASC03.CDX	1	X_ASCII + X_TITLE + X_FILE + X_FIELD
ASCIIXRE	ASC04.CDX	1	Y_ASCII + Y_TITLE + Y_FILE + Y_FIELD + Y_THEIRS
EXTRACTS	EXT01.CDX	1	E_EXTRACT + E_USER + E_SEQ
FILELIST	FLIST.CDX	1	MASTER + ORDER
HELPTXT	HELP01.CDX	1	FUNC_NAME
LOCLLOOK	LOCLLOOK.CDX	1	L_FILE + L_FIELD
MERGHOLD	MER01.CDX	1 2	KEEP_ID TOSS_ID
MMWRYEAR	MMWRDESC.CDX	1	MMWR_YEAR descending
USERS	USERS01.CDX	1	USER_ID