MACS

FOLLOW-UP VISIT
PHYSICAL EXAM

MARKING INSTRUCTIONS

- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make **NO** stray marks.
- Do **NOT** fold this form.

Correct Mark: ●
Incorrect Marks: ✗ ✓ ⋯ ∘

VISIT NUMBER	CLINICIAN NUMBER
0 0	0
1 1 1	10 1
2 2 2	20 2
3 3 3	30 3
4 4	40 4
5 5	50 5
6 6	60 6
7 7	70 7
8 8	80 8
9 9	90 9

1. ID NUMBER

	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
	6	6	6	6
	7	7	7	7
	8	8	8	8
	9	9	9	9

2. DATE

	DAY	YR
JAN ◯		
FEB ◯		
MAR ◯	0 0	
APR ◯	10 1	
MAY ◯	20 2	
JUNE ◯	30 3	
JULY ◯	4	01 ◯
AUG ◯	5	02 ◯
SEPT ◯	6	
OCT ◯	7	
NOV ◯	8	
DEC ◯	9	

3. WEIGHT

POUNDS		
0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
	6	6
	7	7
	8	8
	9	9

4. BLOOD PRESSURE
Sitting, Right Arm

SYSTOLIC			DIASTOLIC		
0	0	0	0	0	0
1	1	1	1	1	1
2	2	2		2	2
	3	3		3	3
	4	4		4	4
	5	5		5	5
	6	6		6	6
	7	7		7	7
	8	8		8	8
	9	9		9	9

5. ORAL TEMPERATURE
At least 30 minutes after smoking, eating, or drinking

			.	°F
	0	0	0	0
	1	1	1	1
		2	2	2
		3	3	3
		4	4	4
		5	5	5
		6	6	6
		7	7	7
		8	8	8
		9	9	9

6. SKIN/HAIR/NAILS (Excluding genital area)

a. Fungal infection lesions (excluding athletes foot)

	NO	YES
1) Intertriginous candida	◯	◯
2) Tinea versicolor	◯	◯
3) Onychomycosis	◯	◯

b. Herpes Zoster (active)	◯	◯
c. Molluscum contagiosum	◯	◯
d. Seborrhea	◯	◯
e. Psoriasis	◯	◯
f. Jaundice	◯	◯
g. Spider Angioma	◯	◯
h. Other (please describe below)	◯	◯

i. Kaposi's Sarcoma

	NO	YES
1) Skin Lesions	◯	◯

IF YES: Number of lesions
◯ 1–2 ◯ 3–10 ◯ >10

Diameter of largest lesion in cms.

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

cms

2) Oral lesions	◯	◯
3) Anal/perianal lesions	◯	◯

◯ Not examined

Comments:

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7. OROPHARYNGEAL

	NO	YES
a. Consistent with oral thrush/candidiasis	◯	◯
b. Consistent with herpetic lesions	◯	◯
c. Gingivitis/gum disease	◯	◯
d. Oral hairy leukoplakia	◯	◯
e. Other *(please describe below)*	◯	◯

IF YES:
◯ KOH negative
-OR-
◯ KOH positive

8. EYES

	NO	YES
a. Conjuctiva		
1) Redness	◯	◯
2) Discharge	◯	◯
b. Scleral icterus	◯	◯
c. Other *(please describe below)*	◯	◯

9. LYMPH NODES

	NO	YES
a. Are there any nodes present (excluding inguinal and femoral) which are ≥1 cm?	◯	◯

SKIP TO Q 10

b. Presence of node ≥1 cm

1) Occipital	*Right*	◯	◯
	Left	◯	◯
2) Post. auricular	*Right*	◯	◯
	Left	◯	◯
3) Pre-auricular	*Right*	◯	◯
	Left	◯	◯
4) Submental/submandibular	*Right*	◯	◯
	Left	◯	◯
5) Ant. cervical	*Right*	◯	◯
	Left	◯	◯
6) Post. cervical	*Right*	◯	◯
	Left	◯	◯
7) Supraclavicular	*Right*	◯	◯
	Left	◯	◯
8) Axillary	*Right*	◯	◯
	Left	◯	◯
9) Epitrochlear	*Right*	◯	◯
	Left	◯	◯

c. What is the diameter of the largest node present?
◯ 1–2 cm ◯ 2.1–4 cm ◯ >4 cm

	NO	YES
d. Are any of the nodes tender?	◯	◯
e. Are any of the nodes matted?	◯	◯

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10. ABDOMEN

a. Liver

Percussed size in mid-clavicular line

	0	10	20	30	40	50	60	70	80	90	cms
	0	1	2	3	4	5	6	7	8	9	

	NO	YES
1. Ascites	◯	◯
2. Caput Medusa	◯	◯

b. Spleen (Rt. lateral decubitus, flexed knees/hips)

	NO	YES
Palpable on inspiration below left costal margin	◯	◯

Size below LCM

	0	10	20	30	40	50	60	70	80	90	cms
	0	1	2	3	4	5	6	7	8	9	

	NO	YES
c. Other *(please describe below)*	◯	◯

◯ Mark here if either entire rectal exam was declined or sections d) and e).

11. ANAL/RECTAL EXAMINATION

	NO	YES
a. Discharge	◯	◯
b. Herpetic lesions	◯	◯
c. Warts	◯	◯
d. Prostate		
1) Enlarged	◯	◯
2) Tender	◯	◯
e. Digital exam		
1) Tender anal canal	◯	◯
f. Hemorrhoids, external	◯	◯
g. Laceration/Fissure/Fistula	◯	◯
h. Other *(please describe below)*	◯	◯

◯ Mark here if genital exam was declined.

12. GENITALIA

	NO	YES
a. Urethral discharge	◯	◯
b. Testicular atrophy	◯	◯
c. Skin		
1) Condyloma acuminata (warts)	◯	◯
2) Pediculosis	◯	◯
3) Tinea cruris/Candida	◯	◯
4) Herpetic lesions (active)	◯	◯
Other *(please describe below)*	◯	◯

13. EXAMINER'S IMPRESSIONS (use back of page if necessary)

	NORMAL	ABNORMAL	COMMENTS
General Appearance	◯	◯	
Chest and Lungs	◯	◯	
Heart	◯	◯	
Extremities	◯	◯	
Neurological Exam	◯	◯	

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14. PERIPHERAL NEUROPATHY SCREENING

	NO	YES
a. Perception of vibration (at great toe)	◯	◯

IF YES: Vibration was felt for: →
- ◯ >10 sec. (normal)
- ◯ 5–10 sec. (mild loss)
- ◯ >0 and <5 sec. (moderate loss)
- ◯ 0 sec. (severe loss)
- ◯ Unable to evaluate

	NO	YES
b. Deep tendon reflexes (ankle reflexes)	◯	◯

IF YES: Reflexes felt were: →
- ◯ Absent
- ◯ Hypoactive
- ◯ Normal deep tendon reflexes
- ◯ Hyperactive deep tendon reflexes (e.g., with prominent spread)
- ◯ Clonus
- ◯ Unable to evaluate

Additional Comments:

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LIPODYSTROPHY SELF-REPORT QUESTIONNAIRE

1a. Since your last visit in [MONTH], have you noticed any changes in the distribution or in the amount of your body fat (either loss or gain)? [Changes include first time occurrences and increases or decreases in severity since your last visit.]

◯ NO (IF "NO", SKIP TO QUESTION 3)
◯ YES

1b. If "yes" which parts of your body were affected, and how severely?

[ASK EACH ITEM AND RECORD ANSWER]

	If No, go to next question. If Yes, indicate severity of symptom.		Current Severity			
	No	Yes	None	Mild	Moderate	Severe
1) Facial fat loss (sunken cheeks)	◯	◯	◯	◯	◯	◯
2) Arm fat loss	◯	◯	◯	◯	◯	◯
3) Leg fat loss	◯	◯	◯	◯	◯	◯
4) Buttocks fat loss	◯	◯	◯	◯	◯	◯
5) Belly (abdomen) fat gain	◯	◯	◯	◯	◯	◯
6) Fat pad (hump) on back of neck	◯	◯	◯	◯	◯	◯
7) Breasts fatter	◯	◯	◯	◯	◯	◯
8) Other *(if Yes, specify below)*	◯	◯				

_____

1c. Since you've noticed these changes, have you taken actions that would influence your fat distribution such as:

[ASK EACH ITEM AND RECORD ANSWER]

	No	Yes
1) Changing diet	◯	◯
2) Changing HIV medications	◯	◯
3) Exercise/Weight lifting	◯	◯
4) Taking supplements	◯	◯
5) Taking growth hormone or steroids	◯	◯
6) Liposuction surgery	◯	◯
7) Other *(if Yes, specify below)*	◯	◯

_____

2. Since your last visit in [MONTH], have you noticed any <u>change</u> in:

	If No, go to next question. If Yes, indicate if change was an increase or decrease and the amount of change.		*Mark only one*		*Amount of change since your last visit.*		
	No	Yes	Increase	Decrease	<1 in.	1–2 in.	>2 in.
1) Shirt neck size	◯	◯	◯	◯	◯	◯	◯
2) Trouser waist size	◯	◯	◯	◯	◯	◯	◯

3. Since your last visit in [Month], have you been told by a medical practitioner that you have:

	No	Yes
1) High blood cholesterol level?	◯	◯
2) High blood triglyceride level?	◯	◯
3) High blood pressure?	◯	◯

	No	Yes	
4. Since your last visit in [Month], have you been told by a medical practitioner that you have high blood sugar, diabetes, or sugar diabetes?	◯	◯	(IF "NO", GO TO NEXT PAGE)
5. Have you taken insulin since your last visit?	◯	◯	(IF "NO", GO TO NEXT PAGE)
6. Are you now taking insulin?	◯	◯	

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LIPODYSTROPHY PHYSICAL EXAMINATION

1. Height:	2. Chest Girth:	3. Waist Girth:	4. Hip Girth:	5. Mid-Arm Girth:	6. Thigh Girth
inches	cm	cm	cm	cm	cm
(see instructions)	(see instructions)	(see instructions)	(see instructions)	(see instructions)	(see instructions)

7. Fat Wasting (see severity definitions below):

If None, go to next question. If Yes, indicate severity of symptom.

	None	Yes	Severity* Mild	Moderate	Severe
1) Facial fat loss (sunken cheeks)	○	○	○	○	○
2) Arms	○	○	○	○	○
3) Legs	○	○	○	○	○
4) Buttocks	○	○	○	○	○

8. Fat Accumulation:

If None, go to next question. If Yes, indicate severity of symptom.

	None	Yes	Severity* Mild	Moderate	Severe
1) Moon facies	○	○	○	○	○
2) Abdomen	○	○	○	○	○
3) Back of Neck	○	○	○	○	○
4) Breasts	○	○	○	○	○

9. Other physical exam findings noted related to fat distribution:

Specify:

*** Definitions:**

None: Patient does not exhibit any signs of fat maldistribution. (Not noted by patient or clinician)

Mild: Mild signs noted only after close inspection by patient or clinician.

Moderate: Signs of fat maldistribution are noticed by patient or clinician without specifically looking for it. Patient may complain that current clothing has become tighter.

Severe: Signs of fat maldistribution easily noted by casual observer. Symptoms have required a change in size of clothing or undergarments worn.

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