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
4 0 0	

1. ID NUMBER

2. DATE

	DAY	YR
JAN		
FEB		
MAR	0 0	00
APR	10 1	01
MAY	20 2	02
JUNE	30 3	03
JULY	4	04
AUG	5	05
SEPT	6	06
OCT	7	07
NOV	8	08
DEC	9	09

3. WEIGHT POUNDS

4. BLOOD PRESSURE Sitting, Right Arm — SYSTOLIC / DIASTOLIC

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

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	◯	◯
IF YES: ◯ KOH negative -OR- ◯ KOH positive ◯ Not performed		
b. Consistent with herpetic lesions	◯	◯
c. Gingivitis/gum disease	◯	◯
d. Oral hairy leukoplakia	◯	◯
e. Other *(please describe below)*	◯	◯

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

		NO	YES
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

RIGHT

	NO	YES
a1. 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

LEFT

	NO	YES
a2. 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

RIGHT

	NO, reflexes absent	YES, reflexes present
b1. Deep tendon reflexes (ankle reflexes)	◯	◯

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

LEFT

	NO, reflexes absent	YES, reflexes present
b2. Deep tendon reflexes (ankle reflexes)	◯	◯

IF YES: Reflexes felt were: →
- ◯ 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 type of change and severity of symptom.		*Was this change an increase or decrease?*		Current Severity		
	No	Yes	Increase	Decrease	Mild	Moderate	Severe
1) Facial fat	○	○	○	○	○	○	○
2) Arm fat	○	○	○	○	○	○	○
3) Leg fat	○	○	○	○	○	○	○
4) Buttocks fat	○	○	○	○	○	○	○
5) Belly (abdomen) fat	○	○	○	○	○	○	○
6) Fat on back of neck	○	○	○	○	○	○	○
7) Breasts	○	○	○	○	○	○	○
8) Waist	○	○	○	○	○	○	○
9) Hips	○	○	○	○	○	○	○
10) 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		No	Yes
1) Changing diet	○	○	6) Liposuction surgery	○	○
2) Changing HIV medications	○	○	7) Cheek implants/injections	○	○
3) Exercise/Weight lifting	○	○	8) Other cosmetic surgery	○	○
4) Taking nutritional supplements	○	○	9) Other *(if Yes, specify below)*	○	○
5) Taking growth hormone or steroids	○	○			

_____

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: (We mean a new diagnosis or an uncontrolled condition.)

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

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? (We mean a new diagnosis or an uncontrolled condition.) No ○ Yes ○ (IF "NO", GO TO NEXT PAGE)

5. Have you taken insulin since your last visit? No ○ Yes ○ (IF "NO", GO TO NEXT PAGE)

6. Are you now taking insulin? No ○ Yes ○

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LIPODYSTROPHY PHYSICAL EXAMINATION

1. Height: inches (see instructions)

2. Chest Girth: cm (see instructions)

2a. Breast Skinfold: mm

3. Waist Girth: cm (see instructions)

3a. Abdomen Skinfold: mm

4. Hip Girth: cm (see instructions)

5. Mid-Arm Girth: cm (see instructions)

5a. Bi-cep Skinfold: mm

5b. Tri-cep Skinfold: mm

6. Thigh Girth cm (see instructions)

6a. Thigh Skinfold: mm

7. Fat Wasting (see severity definitions below):

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

	None	Yes	Severity* Mild	Severity* Moderate	Severity* 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	Severity* Moderate	Severity* 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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Cuestionario
Auto-informe de Lipodistrofía

1a. Desde su última visita en [MES], ¿ha notado cambios en la distribución o en la cantidad de grasa en su cuerpo (tanto, pérdida como aumento de grasa)? [Estos cambios se refieren a la primera vez que ocurrieron y el nivel de gravedad durante estos últimos dos años.]

◯ No **(IF "NO", SKIP TO QUESTION 3)**
◯ Sí

1b. Si contestó que "Sí" a la primera pregunta, ¿cuáles partes de su cuerpo fueron afectadas y cuán grave fue?

[ASK EACH ITEM AND RECORD ANSWER]	*If No, go to next question. If Yes, indique tipo de cambio y gravedad del cambio*		*¿Fué este cambio aumento o pérdida?*		Gravedad del cambio		
	No	Sí	Aumento	Pérdida	Alguna	Moderada	Severa
1) Grasa facial	◯	◯	◯	◯	◯	◯	◯
2) Grasa en los brazos	◯	◯	◯	◯	◯	◯	◯
3) Grasa en las piernas	◯	◯	◯	◯	◯	◯	◯
4) Grasa en los glúteos	◯	◯	◯	◯	◯	◯	◯
5) Grasa en el abdomen	◯	◯	◯	◯	◯	◯	◯
6) Grasa detrás del cuello	◯	◯	◯	◯	◯	◯	◯
7) Grasa en los senos	◯	◯	◯	◯	◯	◯	◯
8) Cintura	◯	◯	◯	◯	◯	◯	◯
9) Cadera	◯	◯	◯	◯	◯	◯	◯
10) Otro *(especifique)*	◯	◯	◯	◯	◯	◯	◯

_____

1c. Desde qué notó estos cambios, ¿ha hecho usted algo para influir en la distribución de grasa en su cuerpo? Por ejemplo:

[ASK EACH ITEM AND RECORD ANSWER]	No	Sí		No	Sí
1) Cambiar la dieta	◯	◯	6) Liposucción	◯	◯
2) Cambiar los medicamentos contra el VIH	◯	◯	7) Implantes en las mejillas/inyecciones	◯	◯
3) Hacer ejercicios/levantamiento de pesas	◯	◯	8) Otra sirugía cosmética	◯	◯
4) Tomar suplementos nutritivos	◯	◯	9) Otro *(especifique)*	◯	◯
5) Tomar hormonas de crecimiento o esteroides	◯	◯			

_____

2. Desde su última visita en [MES], ¿ha notado <u>cambio</u> en:

	If No, go to next question. If Yes, indicate if change was an increase or decrease and the amount of change.		*Mark only one*		*Tamaño del cambio en los últimos dos años*		
	No	Sí	Aumento	Pérdida	<1 in.	1–2 in.	>2 in.
1) Tamaño del cuello/camisa?	◯	◯	◯	◯	◯	◯	◯
2) Tamaño de cintura/pantalón?	◯	◯	◯	◯	◯	◯	◯

In.= pulgadas

3. Desde su última visita en [MES], ¿le ha dicho su médico que usted tiene:

	No	Sí
1) Nivel alto de colesterol en la sangre?	◯	◯
2) Niveles altos de triglicéridos en la sangre?	◯	◯
3) Presión sanguínea alta?	◯	◯

	No	Sí	
4. Desde su última visita en [MES], ¿le ha dicho su médico que usted tiene alto nivel de azúcar en la sangre, o diabetes, o diabetes de azúcar?	◯	◯	(IF "NO", GO TO NEXT PAGE)
5. ¿Ha tomado insulina desde su última visita?	◯	◯	(IF "NO", GO TO NEXT PAGE)
6. ¿Está tomando insulina actualmente?	◯	◯	

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