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 6 0	

1. ID NUMBER

2. DATE — JAN, FEB, MAR, APR, MAY, JUNE, JULY, AUG, SEPT, OCT, NOV, DEC; DAY; YR 00, 01, 02, 03, 04, 05, 06, 07, 08, 09

3. WEIGHT — KILOGRAMS

4.a

	NO	YES
Did participant refrain from caffeine and nicotine for at least 30 minutes prior to first BP reading?	○	○
Did participant sit quietly for about 5 minutes prior to first BP reading?	○	○
Did participant sit quietly for about 5 minutes prior to second BP reading?	○	○

4.b BLOOD PRESSURE ARM

○ Right
○ Left

FIRST READING	SECOND READING
BLOOD PRESSURE Sitting, Right Arm	BLOOD PRESSURE Sitting, Right Arm
SYSTOLIC / DIASTOLIC	SYSTOLIC / DIASTOLIC

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

Q 6–Q 14 NOT COMPLETED DUE TO:

○ Participant refused this section
○ No clinician available

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

	NO	YES	REFUSED
a. Fungal infection lesions (excluding athletes foot)			
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	REFUSED
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

	NO	YES	REFUSED
2) Oral lesions	○	○	○
3) Anal/perianal lesions	○	○	○

○ Not examined

Comments:

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7. OROPHARYNGEAL

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

9. LYMPH NODES

	NO	YES	REFUSED
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?	◯	◯

10. ABDOMEN

a. Liver

Percussed size in mid-clavicular line — REFUSED ◯

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

	NO	YES	REFUSED
1. Ascites	◯	◯	◯

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

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

Did the MACS perform an anal/rectal exam on this participant within the past 6 months?

◯ NO ◯ YES **IF YES, SKIP TO Q 12 GENITALIA EXAM**

◯ **Mark here if entire rectal exam was declined**

11. ANAL/RECTAL EXAMINATION

	NO	YES	REFUSED
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 genitalia exam was declined**

12. GENITALIA

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

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

	NORMAL	ABNORMAL	NOT PERFORMED	COMMENTS
General Appearance	◯	◯	◯	
Chest and Lungs	◯	◯	◯	
Heart	◯	◯	◯	
Extremities	◯	◯	◯	
Neurological Exam	◯	◯	◯	

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14. PERIPHERAL NEUROPATHY SCREENING

RIGHT

a1. Perception of vibration (at great toe)

- ◯ NO
- ◯ YES
- ◯ Unable to evaluate
- ◯ REFUSED

IF YES: Vibration was felt for: →

- ◯ >10 sec. (normal)
- ◯ 5–10 sec. (mild loss)
- ◯ >0 and <5 sec. (moderate loss)
- ◯ 0 sec. (severe loss)

LEFT

a2. Perception of vibration (at great toe)

- ◯ NO
- ◯ YES
- ◯ Unable to evaluate
- ◯ REFUSED

IF YES: Vibration was felt for: →

- ◯ >10 sec. (normal)
- ◯ 5–10 sec. (mild loss)
- ◯ >0 and <5 sec. (moderate loss)
- ◯ 0 sec. (severe loss)

RIGHT

b1. Deep tendon reflexes (ankle reflexes)

- ◯ NO, reflexes absent
- ◯ YES, reflexes present
- ◯ Unable to evaluate
- ◯ REFUSED

IF YES: Reflexes felt were: →

- ◯ Hypoactive
- ◯ Normal deep tendon reflexes
- ◯ Hyperactive deep tendon reflexes (e.g., with prominent spread)
- ◯ Clonus

LEFT

b2. Deep tendon reflexes (ankle reflexes)

- ◯ NO, reflexes absent
- ◯ YES, reflexes present
- ◯ Unable to evaluate
- ◯ REFUSED

IF YES: Reflexes felt were: →

- ◯ Hypoactive
- ◯ Normal deep tendon reflexes
- ◯ Hyperactive deep tendon reflexes (e.g., with prominent spread)
- ◯ Clonus

Additional Comments:

LIPODYSTROPHY 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 PAGE 6)
- ◯ YES
- ◯ REFUSED (IF "REFUSED", SKIP TO PAGE 6)

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

[ASK EACH ITEM AND RECORD ANSWER]

	If No or Refused, go to next question. If Yes, indicate type of change and severity of symptom.			*Was this change an increase or decrease?* →		Current Severity			
	Refused	No	Yes	Increase	Decrease	None	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) Hips	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
9) 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	Refused		No	Yes	Refused
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 or Refused, go to next question. If Yes, indicate if change was an increase or decrease and the amount of change.			*Was this change an increase or decrease?* →		*Amount of change since your last visit.*		
	Refused	No	Yes	Increase	Decrease	<1 in.	1–2 in.	>2 in.
1) Shirt neck size?	◯	◯	◯ →	◯	◯	◯	◯	◯
2) Trouser waist size?	◯	◯	◯ →	◯	◯	◯	◯	◯

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LIPODYSTROPHY PHYSICAL EXAMINATION

1. Height: cm — REFUSED — (see instructions)

2. Mid-Arm Girth: cm — REFUSED — (see instructions)

3. Chest Girth: cm — REFUSED — (see instructions)

4. Waist Girth: cm — REFUSED — (see instructions)

5. Hip Girth: cm — REFUSED — (see instructions)

6. Thigh Girth cm — REFUSED — (see instructions)

LIPODYSTROPHY MEASURER CODE

7. Thigh Skinfold: mm — REFUSED

8. Triceps Skinfold: mm — REFUSED

9. Subscapular Skinfold: mm — REFUSED

10. Biceps Skinfold: mm — REFUSED

11. Breast Skinfold: mm — REFUSED

12. Abdominal Skinfold: mm — REFUSED

13. Suprailiac Skinfold: mm — REFUSED

14. Fat Wasting (see severity definitions below):

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

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

15. Fat Accumulation:

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

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

*** 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.

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

Specify: