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

1. ID NUMBER

2. DATE — JAN, FEB, MAR, APR, MAY, JUNE, JULY, AUG, SEPT, OCT, NOV, DEC; DAY; YR 09, 10, 11, 12, 13, 14, 15, 16, 17, 18

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 — BLOOD PRESSURE Sitting, Right Arm — SYSTOLIC / DIASTOLIC

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

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

SECTION NOT COMPLETED DUE TO:

PAGES 1–4
○ Participant refused this section
○ No clinician available

PAGES 5–6
○ Participant refused lipo section
○ No lipo examiner available

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

a. Fungal infection lesions (excluding athletes foot)

	NO	YES	REFUSED
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

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
	0	1	2	3	4	5	6	7	8	9

cms

	NO	YES	REFUSED
1. Ascites	◯	◯	◯

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

	NO	YES	REFUSED
Palpable on inspiration below left costal margin	◯	◯	◯

IF PALPABLE, indicate size. Otherwise, leave size box blank.

Size below LCM

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

cms

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

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

◯ No

◯ Yes → **If yes: Perform only PAP if consented for study and skip to genitalia. Rectal exam may still be performed if requested.**

PAP study consent obtained?

◯ Yes, PAP cytology and HPV test

◯ Yes, PAP cytology only

→ **Perform annual rectal exam/collect swab**

◯ No → ◯ **Mark here if rectal exam was declined**

11. ANAL/RECTAL EXAMINATION

	NO	YES	REFUSED
a. Anal swab collected for:			
1) Cytology test	◯	◯	◯
2) HPV test	◯	◯	◯
b. Discharge	◯	◯	◯
c. Herpetic lesions	◯	◯	◯
d. Warts	◯	◯	◯
e. Prostate			
1) Enlarged	◯	◯	◯
2) Tender	◯	◯	◯
f. Digital exam			
1) Tender anal canal	◯	◯	◯
g. Hemorrhoids, external	◯	◯	◯
h. Laceration/Fissure/Fistula	◯	◯	◯
i. Other conditions *(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 in 10.c)*	◯	◯	◯

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 (See training video at *http://www.calcaprt.com/macs/macs.htm*).

RIGHT

a1. Perception of vibration (at great toe)
(Use a 128 Hz tuning fork)

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

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

LEFT

a2. Perception of vibration (at great toe)
(Use a 128 Hz tuning fork)

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

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

Cuestionario 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 cambios que ocurren por primera vez y aumentos o disminuciones en la gravedad desde su última visita.]

- ◯ No (SI DIJO "NO", PASE A LA PÁGINA 6)
- ◯ Sí
- ◯ Se negó (SI "SE NEGÓ", PASE A LA PÁGINA 6)

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

Si dijo "no" o "se negó", pase a la siguiente pregunta. Si dijo "sí", indique tipo de cambio y gravedad actual.

¿Fué este cambio aumento o pérdida? →

Gravedad Actual

[ASK EACH ITEM AND RECORD ANSWER]	Se negó	No	Sí	Aumento	Pérdida	Nunca	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) Cadera	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
9) Otro *(especifique)*	◯	◯	◯ →	◯	◯	◯	◯	◯	◯

_____

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

[LEA CADA UNO Y MARQUE LA RESPUESTA]	No	Sí	Se negó
1) Cambiar la dieta	◯	◯	◯
2) Cambiar los medicamentos contra el VIH	◯	◯	◯
3) Hacer ejercicios/levantamiento de pesas	◯	◯	◯
4) Tomar suplementos nutritivos	◯	◯	◯
5) Tomar hormonas de crecimiento o esteroides	◯	◯	◯
6) Liposucción	◯	◯	◯
7) Implantes en las mejillas/inyecciones	◯	◯	◯
8) Otra cirugía cosmética	◯	◯	◯
9) Otro *(especifique)*	◯	◯	◯

_____

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

Si dijo "no" o "se negó", pase a la siguiente pregunta. Si dijo "sí", indique tipo de cambio y cantidad del cambio.

¿Fué este cambio aumento o pérdida? →

Cantidad del cambio desde su última visita

	Se negó	No	Sí	Aumento	Pérdida	<1 in.	1–2 in.	>2 in.
1) Talla del cuello/camisa?	◯	◯	◯ →	◯	◯	◯	◯	◯
2) Talla de la cintura/pantalón?	◯	◯	◯ →	◯	◯	◯	◯	◯

In.= pulgadas

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LIPODYSTROPHY PHYSICAL EXAMINATION

1. Height:	2. Neck Girth:	3. Waist Girth:	4. Hip Girth:	5. Thigh Girth	LIPODYSTROPHY MEASURER CODE
cm	cm	cm	cm	cm	
REFUSED	REFUSED	REFUSED	REFUSED	REFUSED	
(see instructions)	(see instructions)	(see instructions)	(see instructions)	(see instructions)	

6. 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	○	○	○ →	○	○	○

7. 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.

Q6. Fat Wasting:
The examiner observes and grades the lipoatrophy (both facial and limb) according to the following standards:

For facial lipoatrophy:
a) mild — clearly visible deepened nasolabial folds
b) moderate — evidence of "hollowing out" of cheeks
c) severe — hollowed cheek areas with underlying muscle clearly visible

For limb (arms and legs) lipoatrophy:
a) mild — increased prominence of veins
b) moderate — increased prominence of both veins and muscles
c) severe — a + b with overall thinning appearance of the limb

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

Specify: