

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.



1. ID NUMBER

MACSID			
0	0	0	0
1	1	1	1
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

VISIT NUMBER

VISIT_059	
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

CLINICIAN NUMBER

CLIN_059		
0	0	0
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

2. DATE

JAN	DAY	YR
FEB		
MAR	0 0	09
PEDTM_059		
PEDTD_059		
PEDTY_059		
APR		
MAY		
JUN		
JUL		
AUG	5 14	
SEPT	6 15	
OCT	7 16	
NOV	8 17	
DEC	9 18	

3.a HEIGHT

HEIGHT			
0	0	0	0
1	1	1	1
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

cm

HEIGHTCM_059

(see instructions)

3.b WEIGHT

WEIGHT			
KILOGRAMS			
0	0	0	0
1	1	1	1
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

WEIGHKKG_059

4.a

NO YES

Did participant refrain from caffeine and nicotine for at least 30 minutes prior to first BP reading? **CFNIC_059**

Did participant sit quietly for about 5 minutes prior to first BP reading? **SIT1_059**

Did participant sit quietly for about 5 minutes prior to second BP reading? **SIT2_059**

FIRST READING			
BLOOD PRESSURE Sitting, Right Arm			
SYSTOLIC		DIASTOLIC	
0	0	0	0
1	1	1	1
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

SBP_059
DBP_059

SECOND READING			
BLOOD PRESSURE Sitting, Right Arm			
SYSTOLIC		DIASTOLIC	
0	0	0	0
1	1	1	1
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

SBP2_059
DBP2_059

4.b
BLOOD PRESSURE ARM
 Right **BPARM_059**
 Left

SECTION NOT COMPLETED DUE TO:

PAGES 1-4

PENOC_059 Participant refused this section
 No clinician available

PAGES 5-6

PENOL_059 Participant refused lipo section
 No lipo examiner available

5. ORAL TEMPERATURE
 At least 30 minutes after smoking, eating, or drinking
TEMP_059 °F

0	0	0	0
1	1	1	1
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

6. SKIN/HAIR/NAILS (Excluding genital area) a. Fungal infection lesions (excluding athletes foot) <table style="width: 100%;"> <tr><td></td><td>NO</td><td>YES</td><td>REFUSED</td></tr> <tr><td>1) Intertriginous candida</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>2) Tinea versicolor</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td></tr> <tr><td>3) Onychomycosis</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td></tr> </table> <p>SHNFC_059 SHNFV_059 SHNFO_059 SHNHZ_059</p> <p>b. Herpes Zoster (active) SHNMC_059 c. Molluscum contagiosum SHNSE_059 d. Seborrhea SHNPS_059 e. Psoriasis SNHJA_059 f. Jaundice SHNSA_059 g. Spider Angioma SHNOT_059</p> <p>h. Other (please describe below)</p> <table border="1" style="width: 100%; height: 80px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>		NO	YES	REFUSED	1) Intertriginous candida	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	2) Tinea versicolor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	3) Onychomycosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					i. Kaposi's Sarcoma <table style="width: 100%;"> <tr><td></td><td>NO</td><td>YES</td><td>REFUSED</td></tr> <tr><td>1) Skin Lesions</td><td><input type="radio"/></td><td><input type="radio"/></td><td><input type="radio"/></td></tr> </table> <p>SHNKS_059</p> <p>IF YES: Number of lesions <input type="radio"/> 1-2 <input type="radio"/> 3-10 <input type="radio"/> >10 SHNSL_059</p> <p>Diameter of largest lesion in cms. <table border="1" style="width: 100%; text-align: center;"> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td colspan="10">cms</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> SHNLD_059</p> <p>2) Oral lesions SHNKO_059 3) Anal/perianal lesions SHNKL_059 <input type="radio"/> Not examined SHNNE_059</p> <p><i>Comments:</i> <table border="1" style="width: 100%; height: 120px;"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table></p>		NO	YES	REFUSED	1) Skin Lesions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	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) Intertriginous candida	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																																																												
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0	10	20	30	40	50	60	70	80	90																																																						
cms																																																															
0	1	2	3	4	5	6	7	8	9																																																						

SERIAL #

<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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7. OROPHARYNGEAL NO YES REFUSED

a. Consistent with oral thrush/candidiasis **ENTTH_059**

IF YES:

- KOH negative
- OR-
- KOH positive
- Not performed

ENTKO_059

b. Consistent with herpetic lesions **ENTHP_059**

c. Gingivitis/gum disease **ENTGG_059**

d. Oral hairy leukoplakia **ENTLE_059**

e. Other *(please describe below)* **ENTOT_059**

8. EYES NO YES REFUSED

a. Conjunctiva

1) Redness **EYRED_059**

2) Discharge **EYDIS_059**

b. Scleral icterus **EYSCI_059**

c. Other *(please describe below)* **EYOTH_059**

9. LYMPH NODES NO YES REFUSED

a. Are there any nodes present (excluding inguinal and femoral) which are ≥ 1 cm? **LYND1_059**

SKIP TO Q 10 ←

b. Presence of node ≥ 1 cm

1) Occipital *Right* **OCCR_059**
Left **OCCL_059**

2) Post. auricular *Right* **POAUR_059**
Left **POAUL_059**

3) Pre-auricular *Right* **PRAUR_059**
Left **PRAUL_059**

4) Submental/submandibular *Right* **SUBMR_059**
Left **SUBML_059**

5) Ant. cervical *Right* **ACERR_059**
Left **ACERL_059**

6) Post. cervical *Right* **PCERR_059**
Left **PCERL_059**

7) Supraclavicular *Right* **SCLVR_059**
Left **SCLVL_059**

8) Axillary *Right* **AXILR_059**
Left **AXILL_059**

9) Epitrochlear *Right* **EPTRR_059**
Left **EPTRL_059**

c. What is the diameter of the largest node present? **LNODD_059**

- 1-2 cm
- 2.1-4 cm
- >4 cm

d. Are any of the nodes tender? NO YES
TENND_059

e. Are any of the nodes matted? **MATND_059**

10. ABDOMEN

a. Liver

REFUSED

Percussed size in mid-clavicular line

<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	cms
<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	

LIVPS_059

NO YES REFUSED

1. Ascites

LIVAS_059

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

NO YES REFUSED

Palpable on inspiration below left costal margin

SPLPL_059

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

Size below LCM

<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	cms
<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	

SPLCM_059

NO YES REFUSED

c. Other conditions (please describe)

ABDOT_059

Perform anal rectal exam, including digital, annually. It may be performed at every visit if requested by the participant. Indicate refusals by filling in the refusal bubble for each exam component. See guidelines for more details.

Physical Examiner instructions for current visit:

- 1. Collect cytology swab **CCYT_059**
- 2. Collect HPV swab **CHPV_059**
- 3. Perform annual rectal exam, including digital **PDREX_059**

11. ANAL/RECTAL EXAMINATION

NO YES REFUSED

a. Anal swab collected for:

- 1) Cytology test **ARCYT_059**
- 2) HPV test **ARHPV_059**
- b. Visual exam **ARDIS_059**
 - 1) Discharge **ARHPL_059**
 - 2) Herpetic lesions **ARWRT_059**
 - 3) Warts **ARHEM_059**
 - 4) Hemorrhoids, external **ARLFF_059**
 - 5) Laceration/fissure/fistula

c. Digital exam

- 1) Tender anal canal **ARTAC_059**
- 2) Prostate
- 2.a) enlarged **ARPLG_059**
- 2.b) tender **ARPTN_059**

d. Other conditions

(please describe below) **AROTH_059**

12. GENITALIA

NO YES REFUSED

a. Urethral discharge

GPDIS_059

b. Skin

- 1) Condyloma acuminata (warts) **GSWRT_059**
- 2) Pediculosis **GSPED_059**
- 3) Tinea cruris/Candida **GSTCR_059**
- 4) Herpetic lesions (active) **GSHPL_059**

c. Other (please describe in 10.c)

NO YES REFUSED

GOTH_059

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

	NORMAL	ABNORMAL	NOT PERFORMED	COMMENTS
General Appearance	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXIGA_059
Chest and Lungs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXICL_059
Heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXIHT_059
Extremities	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXIET_059
Neurological Exam	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	EXINE_059

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<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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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) **PNPVR_059**

(Use a 128 Hz tuning fork)

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

- IF YES: Vibration** >10 sec. (normal) **PNVTR_059**
 was felt for: —> 5–10 sec. (mild loss)
 >0 and <5 sec. (moderate loss)

LEFT

a2. Perception of vibration (at great toe) **PNPVL_059**

(Use a 128 Hz tuning fork)

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

- IF YES: Vibration** >10 sec. (normal) **PNVTL_059**
 was felt for: —> 5–10 sec. (mild loss)
 >0 and <5 sec. (moderate loss)

RIGHT

b1. Deep tendon reflexes (ankle reflexes) **PNTRR_059**

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

- IF YES: Reflexes** Hypoactive **PNTRR_059**
 felt were: —> Normal deep tendon reflexes
 Hyperactive deep tendon reflexes
 (e.g., with prominent spread)
 Clonus

LEFT

b2. Deep tendon reflexes (ankle reflexes) **PNTRL_059**

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

- IF YES: Reflexes** Hypoactive **PNTRL_059**
 felt were: —> 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.] **LDFAT_059**

- 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]

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	<input type="radio"/> LFACE_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHFAC_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVFAC_059	<input type="radio"/>	<input type="radio"/>
2) Arm fat	<input type="radio"/> LARM_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHARM_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVARM_059	<input type="radio"/>	<input type="radio"/>
3) Leg fat	<input type="radio"/> LLEG_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHLEG_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVLEG_059	<input type="radio"/>	<input type="radio"/>
4) Buttocks fat	<input type="radio"/> LBUT_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHBUT_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVBUT_059	<input type="radio"/>	<input type="radio"/>
5) Belly (abdomen) fat	<input type="radio"/> LABD_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHABD_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVABD_059	<input type="radio"/>	<input type="radio"/>
6) Fat on back of neck	<input type="radio"/> LPAD_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHPAD_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVPAD_059	<input type="radio"/>	<input type="radio"/>
7) Breasts	<input type="radio"/> LBRS_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHBRS_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVBRS_059	<input type="radio"/>	<input type="radio"/>
8) Hips	<input type="radio"/> LHIP_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHHIP_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVHIP_059	<input type="radio"/>	<input type="radio"/>
9) Other (if Yes, specify below)	<input type="radio"/> LDOTH_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> CHOT_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> SVOTH_059	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/> CHDIT_059	<input type="radio"/>	<input type="radio"/>	6) Liposuction surgery	<input type="radio"/> CHSUR_059	<input type="radio"/>
2) Changing HIV medications	<input type="radio"/> CHHIV_059	<input type="radio"/>	<input type="radio"/>	7) Cheek implants/injections	<input type="radio"/> CHCHK_059	<input type="radio"/>
3) Exercise/Weight lifting	<input type="radio"/> CHWGT_059	<input type="radio"/>	<input type="radio"/>	8) Other cosmetic surgery	<input type="radio"/> CHCMS_059	<input type="radio"/>
4) Taking nutritional supplements	<input type="radio"/> CHSUP_059	<input type="radio"/>	<input type="radio"/>	9) Other (if Yes, specify below)	<input type="radio"/> CHOTH_059	<input type="radio"/>
5) Taking growth hormone or steroids	<input type="radio"/> CHSTR_059	<input type="radio"/>	<input type="radio"/>			

2. Since your last visit in [MONTH], have you noticed any change 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?	<input type="radio"/> CHNCK_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> IDNCK_059	<input type="radio"/>	<input type="radio"/> ATNCK_059	<input type="radio"/>	<input type="radio"/>
2) Trousler waist size?	<input type="radio"/> CHWST_059	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> IDWST_059	<input type="radio"/>	<input type="radio"/> ATWST_059	<input type="radio"/>	<input type="radio"/>

SERIAL #

LIPODYSTROPHY PHYSICAL EXAMINATION

1. Neck Girth:

cm
LDNEC_059

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

(see instructions)

2. Waist Girth:

cm
LDWAI_059

1	1	1	1
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

(see instructions)

3. Hip Girth:

cm
LDHIP_059

1	1	1	1
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

(see instructions)

4. Thigh Girth

cm
LDTHI_059

1	1	1	1
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

(see instructions)

LIPODYSTROPHY
 MEASURER CODE
LPEXN_059

0	0	0
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

