



**7. OROPHARYNGEAL**

NO YES

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

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**8. EYES**

NO YES

- a. Conjunctiva
  - 1) Redness  NO  YES
  - 2) Discharge  NO  YES
- b. Scleral icterus  NO  YES
- c. Other (please describe below)  NO  YES

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**9. LYMPH NODES**

NO YES

- a. Are there any nodes present (excluding inguinal and femoral) which are  $\geq 1$  cm?  NO  YES

**SKIP TO Q 10**

- b. What is the diameter of the largest node present?
  - 1-2 cm
  - 2.1-4 cm
  - >4 cm

- c. Are any of the nodes tender?  NO  YES
- d. Are any of the nodes matted?  NO  YES

**10. ABDOMEN**

**a. Liver**

Enlarged liver definition >3 cm below the right costal margin measured at the mid-clavicular line

- 1. Enlarged  NO  YES
- 2. Tender  NO  YES

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

- Palpable on inspiration below left costal margin  NO  YES

**c. Other conditions (please describe)**

NO YES

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**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:**

Perform annual rectal exam, including digital  No  Yes

**11. ANAL/RECTAL EXAMINATION**

NO YES REFUSED

**a. Visual exam**

- 1) Discharge  NO  YES  REFUSED
- 2) Herpetic lesions  NO  YES  REFUSED
- 3) Warts  NO  YES  REFUSED
- 4) Hemorrhoids, external  NO  YES  REFUSED
- 5) Laceration/fissure/fistula  NO  YES  REFUSED

**b. Digital exam**

- 1) Tender anal canal  NO  YES  REFUSED
- 2) Prostate  NO  YES  REFUSED
  - 2.a) enlarged  NO  YES  REFUSED
  - 2.b) tender  NO  YES  REFUSED

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

NO  YES  REFUSED

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**12. GENITALIA**

NO YES REFUSED

- a. Urethral discharge  NO  YES  REFUSED
- b. Skin
  - 1) Condyloma acuminata (warts)  NO  YES  REFUSED
  - 2) Tinea cruris/Candida  NO  YES  REFUSED
  - 3) Herpetic lesions (active)  NO  YES  REFUSED
- c. Circumcized  NO  YES  REFUSED
- d. Other (please describe in 10.c)  NO  YES  REFUSED



**15a. STANDING BALANCE:**

	TIME HELD (stop watch at 10 seconds)	UNABLE	REFUSED	EXPLAIN:																																								
1. Side-by-side stand	<table border="1"> <tr><td>0</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></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> <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> <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>	0	1									0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	<input type="radio"/>	<input type="radio"/>	   
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2. Semi-tandem stand	<table border="1"> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td></td><td></td><td></td><td></td><td></td><td></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> <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> <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>	0	1	2	3							0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	<input type="radio"/>	<input type="radio"/>	   
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3. Tandem stand	<table border="1"> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td></td><td></td><td></td><td></td><td></td><td></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> <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> <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>	0	1	2	3							0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	<input type="radio"/>	<input type="radio"/>	   
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4. Single leg stand	<table border="1"> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td></td><td></td><td></td><td></td><td></td><td></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> <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> <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>	0	1	2	3							0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	<input type="radio"/>	<input type="radio"/>	   
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**15b. CHAIR STANDS:**

A chair stand starts with the participant in the sitting position and rises up to a stand with legs fully extended, without using his arms. After the initial trial single chair stand, ask the participant to perform 10 chair stands. The clinician should start timing as soon as he/she says go, do a split with the stopwatch when he STANDS for the 5th time, and stop the watch when he STANDS for the 10th time. If unable to do 5 stands, bubble in "unable to do 5 stands". If performed 5 stands, but unable to do 10 stands, record the time for 5 stands and bubble in "unable to do 10 stands". Refer to the guidelines for complete instructions.

	UNABLE	REFUSED	ATTEMPTED, UNABLE TO DO 1	COMPLETED																				
1. Single chair stand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
EXPLAIN WHY UNABLE:	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																							

	UNABLE	REFUSED	ATTEMPTED, UNABLE TO DO 5	ATTEMPTED, BUT UNABLE TO DO 10 (Enter time for first 5 below)	COMPLETED (Enter time for first 5 and all 10 below)																				
2. Repeated chair stand	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
EXPLAIN WHY UNABLE:	<table border="1"> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> <tr><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td><td> </td></tr> </table>																								

TIME FOR FIRST 5 STANDS (Seconds)

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

TIME FOR ALL 10 STANDS (Seconds)

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



# V67 PE Lipodystrophy Form

## 1. MACSID ID

\_\_\_\_\_

**DOB Date of Birth: (mm/dd/yyyy)**

\_\_\_\_/\_\_\_\_/\_\_\_\_

**Visit No.**

**(067)**

**Clinician Number**

\_\_\_\_\_

**2. Date of Visit: (mm/dd/yyyy)**

\_\_\_\_/\_\_\_\_/\_\_\_\_

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## Module 9: Lipodystrophy Questionnaire

**5.0 Q17-18 not completed due to:**

- Participant refused this section*
- no lipo examiner available*

**1a. Do you feel that your body fat distribution is abnormal?**

- No*
- Yes*
- Refused*

**1b. Have you noticed too much (lipohypertrophy) or too little (lipoatrophy) fat on any part of your body?**

- No*
- Yes*
- Refused*

*If “No” or “Refused” stop section.*

**1c. If “Yes,” which parts of your body were affected, and how severely? [Ask each item and record answer]**

## V67 PE Lipodystrophy Form

	<b>If No or Refused, go to next question in table. If Yes, indicate the type of change and severity of symptom. →</b>  No    Yes    Refused	<b>Was this too much or too little fat? →</b>  Too much fat    Too little fat	<b>Current Severity</b>  None    Mild    Moderate    Severe
			<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"/>
<b>1. Facial Fat</b>	<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"/>
<b>2. Arm Fat</b>	<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"/>
<b>3. Leg fat</b>	<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"/>
<b>4. Buttocks Fat</b>	<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"/>
<b>5. Belly (abdomen) fat</b>	<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"/>
<b>6. Fat on back of neck</b>	<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"/>
<b>7. Breasts</b>	<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"/>
<b>8. Hips</b>	<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"/>
<b>9. Other (if yes, specify)</b>	<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"/>
<b>Comments:</b> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/> <hr/>			

# V67 PE Lipodystrophy Form

## Lipodystrophy Physical Examination:

### Lipodystrophy Examiner Code

\_\_\_\_ \_

#### 1. Neck Girth in cm:

\_\_\_\_ \_ . \_\_\_\_

**Refused**

#### 2. Waist Girth in cm:

\_\_\_\_ \_ . \_\_\_\_

**Refused**

#### 3. Hip Girth in cm:

\_\_\_\_ \_ . \_\_\_\_

**Refused**

#### 4. Thigh Girth in cm:

\_\_\_\_ \_ . \_\_\_\_

**Refused**

### *Comments:*

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