

A5. INDICATION FOR TREATMENT (Circle the most severe lesion for each)

- a. Cervical
 - None 1
 - Exophytic condyloma..... 2
 - LG SIL: HPV 3
 - LG SIL: CIN1 (Mild dysplasia) 4
 - LG SIL: Unspecified 5
 - HG SIL: CIN II (Mod dysplasia) 6
 - HG SIL: CIN III (Severe/CIS)..... 7
 - Microinvasive CA 8
 - Invasive CA..... 9
 - Adenocarcinoma - in - situ10
 - Adenocarcinoma 11
 - Other..... 12

(SPECIFY)

- b. Vaginal
 - None 1
 - HPV lesion 2
 - VAIN I..... 3
 - VAIN II 4
 - VAIN III..... 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

- c. Vulvar
 - None 1
 - HPV lesion 2
 - VIN I 3
 - VIN II 4
 - VIN III..... 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

- d. Perianal
 - None 1
 - HPV lesion 2
 - PAIN I 3
 - PAIN II..... 4
 - PAIN III..... 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

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- e. Anal
 - None 1
 - HPV lesion 2
 - AIN I 3
 - AIN II 4
 - AIN III 5
 - Invasive CA 6
 - Other 7

(SPECIFY)

- f. Endometrium
 - None 1
 - Atypical hyperplasia 2
 - Invasive CA 3
 - Other 4

(SPECIFY)

- g. Other Location:
 - Yes 1
 - No 2(A6)

i. Location

(SPECIFY)

ii. Lesion

(SPECIFY)

**A6. INDICATION FOR TREATMENT BASED ON:
(circle yes or no for each indication)**

| | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| a. Suspicious pap smear with inadequate colposcopy | 1 | 2 |
| b. Histologic diagnosis | 1 | 2 |
| c. Pap smear - histologic - colposcopic discrepancy..... | 1 | 2 |
| d. Abnormal colposcopy | 1 | 2 |
| e. Grossly apparent lesion..... | 1 | 2 |
| f. Other..... | 1 | 2 |

(SPECIFY)

WIHS ID #

A7. TREATMENT MODALITY:

a. Cervix (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| 1. None/Observation | 1 (b) | 2 |
| 2. Interferon | 1 | 2 |
| 3. 5 - FU | 1 | 2 |
| 4. Cryotherapy | 1 | 2 |
| 5. Laser vaporization | 1 | 2 |
| 6. Laser conization..... | 1 | 2 |
| 7. LEEP/LLETZ (transformation zone)..... | 1 | 2 |
| 8. LEEP conization | 1 | 2 |
| 9. Cold - knife conization | 1 | 2 |
| 10. Hysterectomy (simple)..... | 1 | 2 |
| 11. Hysterectomy (radical) | 1 | 2 |
| 12. Radiation therapy..... | 1 | 2 |
| 13. Other | 1 | 2 |

(SPECIFY)

b. Vagina (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|-----------------------------------|------------|-----------|
| 1. None/Observation | 1 (c) | 2 |
| 2. TCA | 1 | 2 |
| 3. Podophyllin..... | 1 | 2 |
| 4. Condylox..... | 1 | 2 |
| 5. Interferon | 1 | 2 |
| 6. 5 - FU | 1 | 2 |
| 7. Cryotherapy | 1 | 2 |
| 8. Laser vaporization | 1 | 2 |
| 9. LEEP..... | 1 | 2 |
| 10. Vaginal excision (local)..... | 1 | 2 |
| 11. Vaginectomy..... | 1 | 2 |
| 12. Radiation therapy..... | 1 | 2 |
| 13. Other | 1 | 2 |

(SPECIFY)

c. Vulva (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|-------------------------------|------------|-----------|
| 1. None/Observation..... | 1 (d) | 2 |
| 2. TCA | 1 | 2 |
| 3. Podophyllin..... | 1 | 2 |
| 4. Condylox..... | 1 | 2 |
| 5. Interferon | 1 | 2 |
| 6. 5 - FU..... | 1 | 2 |
| 7. Cryotherapy | 1 | 2 |
| 8. Laser vaporization | 1 | 2 |
| 9. LEEP..... | 1 | 2 |
| 10. Wide local excision | 1 | 2 |
| 11. Vulvectomy..... | 1 | 2 |
| 12. Radiation therapy..... | 1 | 2 |
| 13. Other | 1 | 2 |

(SPECIFY)

d. Perianal (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|-----------------------------|------------|-----------|
| 1. None/Observation..... | 1 (e) | 2 |
| 2. TCA | 1 | 2 |
| 3. Podophyllin..... | 1 | 2 |
| 4. Condylox..... | 1 | 2 |
| 5. Interferon | 1 | 2 |
| 6. 5 - FU..... | 1 | 2 |
| 7. Cryotherapy | 1 | 2 |
| 8. Laser vaporization | 1 | 2 |
| 9. LEEP..... | 1 | 2 |
| 10. Excision | 1 | 2 |
| 11. Radiation therapy..... | 1 | 2 |
| 12. Other | 1 | 2 |

(SPECIFY)

e. Anal (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|-----------------------------|------------|-----------|
| 1. None/Observation..... | 1 (f) | 2 |
| 2. TCA | 1 | 2 |
| 3. Podophyllin..... | 1 | 2 |
| 4. Condylox..... | 1 | 2 |
| 5. Interferon | 1 | 2 |
| 6. 5 - FU..... | 1 | 2 |
| 7. Cryotherapy | 1 | 2 |
| 8. Laser vaporization | 1 | 2 |
| 9. LEEP..... | 1 | 2 |
| 10. Excision | 1 | 2 |
| 11. Radiation therapy..... | 1 | 2 |
| 12. Other | 1 | 2 |

(SPECIFY)

f. Endometrium (circle yes or no for each modality)

| | <u>YES</u> | <u>NO</u> |
|---------------------------------------|------------|-----------|
| 1. None/Observation..... | 1 (g) | 2 |
| 2. Hormone therapy | 1 | 2 |
| 3. Dilation and Curettage (D&C) | 1 | 2 |
| 4. Hysterectomy (simple)..... | 1 | 2 |
| 5. Hysterectomy (radical) | 1 | 2 |
| 6. Radiation therapy..... | 1 | 2 |
| 7. Other | 1 | 2 |

(SPECIFY)

g. Other Location:

Yes1
No.....2(A8)

i. Location:

(SPECIFY)

ii. Modality

(SPECIFY)

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A8. IS THIS PATIENT PART OF ANOTHER STUDY EVALUATION FOR TREATMENT OF DYSPLASIA?

YES 1
NO 2 (A9)

a. SPECIFY NAME OF STUDY: _____

b. SPECIFY NAME OF STUDY SITE: _____

A9. WAS HISTOLOGIC EVALUATION OBTAINED OR BIOPSY PERFORMED DURING THIS TREATMENT PROCEDURE ?

YES 1 (Complete Form L15 for each biopsy performed)
NO 2

A10. FOLLOW UP SCHEDULED?

YES 1
NO 2 (A11)
UNKNOWN.....<-8> (A11)

a. INDICATE SCHEDULED FOLLOW-UP IN WEEKS OR MONTHS:

 |_|_| WEEKS..... 1
 MONTHS..... 2

b. INDICATE TYPE OF FOLLOW-UP PLANNED:

Repeat pap only1
Repeat pap & colposcopy2
Repeat colposcopy only3
Repeat treatment4
Other5

(SPECIFY)

A11. WAS TREATMENT COMPLETED TODAY?

YES, Complete 1
NO, Incomplete 2
Ongoing 3
Delayed 4
Other 5

(SPECIFY)

Refused <-7>
Unknown <-8>

WIHS ID #

A12. HOW WAS THIS INFORMATION OBTAINED?
(circle yes or no for each source)

| | <u>YES</u> | <u>NO</u> |
|--------------------------------------|------------|-----------|
| a. Study personnel | 1 | 2 |
| b. Chart abstraction | 1 | 2 |
| c. Direct contact with provider..... | 1 | 2 |
| d. Patient history | 1 | 2 |
| e. Other | 1 | 2 |

(SPECIFY)

A13. INDICATE PRIMARY SOURCE OF THIS INFORMATION?
(code below even if only one source = yes at A12)

| | <u>YES</u> | <u>NO</u> |
|--------------------------------------|------------|-----------|
| a. Study personnel | 1 | 2 |
| b. Chart abstraction | 1 | 2 |
| c. Direct contact with provider..... | 1 | 2 |
| d. Patient history | 1 | 2 |
| e. Other | 1 | 2 |

(SPECIFY)

A14. Name of person providing treatment on this date:

(Please Print)

A15. Institution (Name or Number): _____
(Please Print)

(ADDRESS)