WOMEN'S INTERAGENCY HIV STUDY
QUESTION-BY-QUESTION SPECIFICATIONS
FORM 7r: PHYSICAL EXAM ADDENDUM

General Instructions:

1. All dates should be recorded in the MM/DD/YY format.
2. Participants should remove all clothing, except underwear. Shoes should be removed; thin socks may be worn, if participant desires. Paper or lightweight cotton gowns should be worn during the entire exam.
3. Indicators for the beginning and end of all subforms have been included on the form. This has been done for data entry purposes only and will not affect how the form is completed.

PARTICIPANT INFORMATION

This section at the beginning of the form should be completed before beginning the physical exam.

SECTION A: GENERAL PHYSICAL CHARACTERISTICS

PROMPT: IF VISIT NUMBER IS EVEN, SKIP TO SECTION B. HEIGHT WILL BE RECORDED ON FORM F07.

A1. Height: Participant should stand with head in Frankfort horizontal plane, shoulders relaxed, arms at sides, legs straight, and feet flat. The participant should take a deep breath and stand as tall as possible. Enter the height of the participant in inches. Round off to the nearest whole number and write in the numeric value. Please do not do any conversions.

> **NOTE**: Frankfort horizontal plane is described by NHANES as: "The head is in the Frankfort plane when the horizontal line from ear canal to the lower border of the orbit of the eye is parallel to the floor and perpendicular to the vertical backboard."

SECTION B: SKIN EXAM

PROMPT: AS YOU PROCEED WITH THE PHYSICAL EXAM, RESPONSES CIRCLED "YES" THAT ARE SHADED REQUIRE PROMPT REFERRAL FOR EVALUATION AND/OR TREATMENT. PLEASE REFER TO YOUR MANUAL FOR REFERRAL GUIDELINES.

B2. Enter the total number of different location codes recorded in **Questions B3** through **B10**. The value must be equal to the number of boxes completed in **Questions B3** through **B10** indicating where lesions are present.

PROMPT: REFER PARTICIPANTS WITH SKIN LESIONS TO MEDICAL PROVIDER AS APPROPRIATE.

B3–B10: **Section B** allows entry of up to eight locations for skin lesions. Descriptive information recorded for each lesion type consists of three parts (a, b and c). For each location code mentioned in **Question B2**, complete one location code box describing the location, characteristics, and diagnosis of the lesion (i.e., complete sections a, b, and c for each lesion location).

a. Using the location codes provided, enter the two-digit code that corresponds to the location of the lesion. If there are two locations at which the same type of lesion is found, each location should be recorded in a separate location box. For example, if eczema is found on the back and legs (codes 07 and 08), record one of the location codes in **Question B3a** and the other in

Question B4a. However, if the same type of lesion is found in three or more locations, use only one location box and record location code “14” (3 or more locations).

b. Using the description codes provided, enter the three-digit code(s) that best describe the physical/clinical characteristics of the lesion. The clinician should choose one primary lesion code and then one or two other description codes to describe the lesion(s) at the locations coded in **Questions B3a** through **B10a**. If there is not a suitable primary lesion code available, record code “140” (other) as the description code without recording a primary lesion code. For example, if participant has onchomycosis, diagnosis code “259” should be recorded in section c; however, since there is no suitable primary lesion code to record in the description codes portion of the question, record code “140” as the description code in section b.

c. Using the diagnosis codes provided, enter the three-digit diagnosis code for the lesion. If the clinician does not know or cannot confirm the diagnosis, record “299.”

Section B can accommodate up to eight lesion locations. If the participant has less than eight lesion locations, follow the **PROMPT** and skip to **Section C**. **If more than eight lesion locations are present, use a copy of page 2 or 3 for recording additional lesion locations.**

SECTION C: ORAL EXAM

C2. Enter the total number of oral lesions present. The value must be equal to the number of boxes completed in **Questions C3** through **C6** indicating where lesions are present.

PROMPT: REFER PARTICIPANTS WITH ORAL LESIONS TO MEDICAL PROVIDER AS APPROPRIATE.

C3–C6: **Section C** allows entry of up to four lesions. Descriptive information recorded for each lesion type consists of four parts (a, b, c and d). For each type of lesion, complete one separate lesion section in **Questions C3** through **C6** in which parts a, b, c and d are completely filled out.

a. Using the location codes provided in the diagram on page 4, enter up to three location codes for each lesion type.

d. Record the presumed diagnosis for each lesion type using 25 characters or less.

Section C can accommodate up to four lesion types. If the participant has less than four lesion types, follow the **PROMPT** and skip to **Section D**. **If more than four lesion types are present, use a copy of page 5 or 6 for recording additional lesions.**

SECTION D: PHYSICAL FINDINGS IN THE BREASTS

PROMPT: IF VISIT NUMBER IS EVEN, CIRCLE “3” IN QUESTION D1 AND THEN SKIP TO SECTION E. BREAST EXAM FINDINGS WILL BE RECORDED ON FORM F07.

D1. Examine and record your overall assessment of the participant’s breasts. If exam is normal or not done, skip to **Section E**.

D9–D18: Be careful to record information from the LEFT and the RIGHT breasts separately and in the proper location on the form. If a breast mass is not found in a region, code “NO,” and skip to the next region (do not complete sub questions “**a**” and “**b**”). If a mass is found, record the size of the mass in centimeters and indicate whether or not this is an old mass. Old mass is defined as:

<u>Old Mass</u>: A persistent, discrete lump or localized thickening in either breast that has been evaluated by a physician, mammogram, needle aspiration or biopsy and that was found to be a benign condition.

SECTION E. PHYSICAL FINDINGS IN THE ABDOMEN

E1. ABDOMINAL EXAM

a. **Enlarged liver:** Palpate with flat of fingers starting at the right lower abdomen working upward towards the right costal margin along the mid-clavicular line. If liver extends below the right costal margin, measure distance from right costal margin to lower edge at mid-clavicular line. If liver extends 3 cm or more below right costal margin at mid-clavicular line, hepatomegaly (enlarged liver) is considered present (code 1 = yes). If no enlargement is noted, code 2 = no.

b. **Splenomegaly:** Palpate with flat of fingers starting at lower abdomen along the mid-sternal line working upwards diagonally to anterior axillary line along the left costal margin. If spleen tip is palpated, or if more than the tip of the spleen is palpated at the left costal margin, splenomegaly (enlarged spleen) is considered present (code 1 = yes). If no enlargement is noted, code 2 = no.

c. **Abdominal Mass:** If an abdominal mass is palpated, code 1 = yes, and then go to Question E1ci and record the diagnosis associated with the mass, if known. If diagnosis is not known, record "unknown" or the acceptable abbreviation for "don't know" *(DK).* If no mass is noted, code 2 = no.

d. **Ascites:** Record whether abdominal ascites is present (code 1 = yes) or absent (code 2 = no).

e. **Other:** If another abdominal abnormality is found, code 1 = yes and specify the abnormality. If no other abnormality is noted, code 2 = no.

PROMPT: REFER PARTICIPANTS WITH ABDOMINAL ABNORMALITIES TO MEDICAL PROVIDER AS APPROPRIATE.

SECTION F: BI-MANUAL EXAM

PROMPT: IF VISIT NUMBER IS EVEN, END FORM. BI-MANUAL EXAM FINDINGS WILL BE RECORDED ON FORM F08.

F1. If the participant has no uterus, skip to **Question F2**.

F2. If the participant has no adnexae, skip to **Question F3.**