

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: ✗ ✓ ✎ ○

LEGEND § = Further Evaluation

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

1. ID NUMBER

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

2. DATE

	DAY	YR
JAN	○	
FEB	○	
MAR	○	0 0
APR	○	10 1
MAY	○	20 2
JUNE	○	30 3
JULY	○	4
AUG	○	5
SEPT	○	6
OCT	○	7 (98)
NOV	○	8 (99)
DEC	○	9

3. WEIGHT

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

4. BLOOD PRESSURE
Sitting, Right Arm

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

§ 5. ORAL TEMPERATURE
At least 30 minutes after smoking, eating, or drinking

°F					
0	0	0	0		
1	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			

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

a. Fungal infection lesions (excluding athletes foot)

- | | NO | YES |
|-----------------------------|-----------------------|-----------------------|
| § 1) Intertriginous candida | <input type="radio"/> | <input type="radio"/> |
| § 2) Tinea versicolor | <input type="radio"/> | <input type="radio"/> |
| § 3) Onychomycosis | <input type="radio"/> | <input type="radio"/> |

b. Herpes Zoster (active) NO YES

c. Molluscum contagiosum NO YES

d. Seborrhea NO YES

e. Psoriasis NO YES

f. Other (please describe below) NO YES

g. Kaposi's Sarcoma

§ 1) Skin Lesions

NO YES

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	cms
	0	1	2	3	4	5	6	7	8	9	

§ 2) Oral lesions

NO YES

§ 3) Anal/perianal lesions

NO YES

Not examined

Comments:



7. OROPHARYNGEAL

NO YES

§ a. Consistent with oral thrush/candidiasis

IF YES:

KOH negative

-OR-

KOH positive

§ b. Consistent with herpetic lesions

§ c. Gingivitis/gum disease

§ d. Oral hairy leukoplakia

e. Other (please describe below)

8. EYES

NO YES

a. Conjunctiva

1) Redness

2) Discharge

b. Scleral icterus

c. Other (please describe below)

9. § LYMPH NODES

NO YES

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

d. Are any of the nodes tender? NO YES

e. Are any of the nodes matted?

10. ABDOMEN

§ a. Liver

Percussed size in mid-clavicular line

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

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

Palpable on inspiration below left costal margin

NO YES

Size below LCM

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

c. Other (please describe below)

NO YES

Mark here if either entire rectal exam was declined or sections d) and e).

11. ANAL/RECTAL EXAMINATION

- | | NO | YES |
|------------------------------------|-----------------------|-----------------------|
| § a. Discharge | <input type="radio"/> | <input type="radio"/> |
| § b. Herpetic lesions | <input type="radio"/> | <input type="radio"/> |
| § c. Warts | <input type="radio"/> | <input type="radio"/> |
| § d. Prostate | | |
| 1) Enlarged | <input type="radio"/> | <input type="radio"/> |
| 2) Tender | <input type="radio"/> | <input type="radio"/> |
| § e. Digital exam | | |
| 1) Tender anal canal | <input type="radio"/> | <input type="radio"/> |
| § f. Hemorrhoids, external | <input type="radio"/> | <input type="radio"/> |
| § g. Laceration/Fissure/Fistula | <input type="radio"/> | <input type="radio"/> |
| § h. Other (please describe below) | <input type="radio"/> | <input type="radio"/> |

Mark here if genital exam was declined.

12. GENITALIA

- | | NO | YES |
|--------------------------------|-----------------------|-----------------------|
| § a. Urethral discharge | <input type="radio"/> | <input type="radio"/> |
| § b. Skin | | |
| 1) Condyloma acuminata (warts) | <input type="radio"/> | <input type="radio"/> |
| 2) Pediculosis | <input type="radio"/> | <input type="radio"/> |
| 3) Tinea cruris/Candida | <input type="radio"/> | <input type="radio"/> |
| 4) Herpetic lesions (active) | <input type="radio"/> | <input type="radio"/> |
| Other (please describe below) | <input type="radio"/> | <input type="radio"/> |

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

	NORMAL	ABNORMAL	COMMENTS
General Appearance	<input type="radio"/>	<input type="radio"/>	
Chest and Lungs	<input type="radio"/>	<input type="radio"/>	
Heart	<input type="radio"/>	<input type="radio"/>	
Extremities	<input type="radio"/>	<input type="radio"/>	
Neurological Exam	<input type="radio"/>	<input type="radio"/>	

Additional Comments:

Lined area for additional comments.



LIPODYSTROPHY SELF-REPORT QUESTIONNAIRE

ID NUMBER			
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

VISIT NO.
3 1
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<input type="text"/>
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<input type="text"/>
<input type="text"/>
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<input type="text"/>

DATE		
MONTH	DAY	YEAR
<input type="radio"/> Jan	<input type="text"/>	<input type="text"/>
<input type="radio"/> Feb	<input type="text"/>	9 9
<input type="radio"/> Mar	<input type="text"/>	<input type="text"/>
<input type="radio"/> Apr	<input type="text"/>	<input type="text"/>
<input type="radio"/> May	<input type="text"/>	<input type="text"/>
<input type="radio"/> June	<input type="text"/>	<input type="text"/>
<input type="radio"/> July	<input type="text"/>	<input type="text"/>
<input type="radio"/> Aug	<input type="text"/>	<input type="text"/>
<input type="radio"/> Sept	<input type="text"/>	<input type="text"/>
<input type="radio"/> Oct	<input type="text"/>	99
<input type="radio"/> Nov	<input type="text"/>	<input type="text"/>
<input type="radio"/> Dec	<input type="text"/>	<input type="text"/>

1a. In the past 2 years, have you noticed any changes in the distribution or in the amount of your body fat (either loss or gain)?

- NO (IF "NO", SKIP TO QUESTION 3)
 YES

1b. If "yes" which parts of your body were affected, and how severely?

[ASK EACH ITEM AND RECORD ANSWER]

If No, go to next question.
 If Yes, indicate severity of symptom.

			Severity		
	No	Yes	Mild	Moderate	Severe
1) Facial fat loss (sunken cheeks)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Arm fat loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Leg fat loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Buttocks fat loss	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Belly (abdomen) fat gain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Fat pad (hump) on back of neck	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) Breasts fatter	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) Other	<input type="radio"/>	<input type="radio"/>	Specify: _____		

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
1) Changing diet	<input type="radio"/>	<input type="radio"/>
2) Changing HIV medications	<input type="radio"/>	<input type="radio"/>
3) Exercise/Weight lifting	<input type="radio"/>	<input type="radio"/>
4) Taking supplements	<input type="radio"/>	<input type="radio"/>
5) Taking growth hormone or steroids	<input type="radio"/>	<input type="radio"/>
6) Liposuction surgery	<input type="radio"/>	<input type="radio"/>
7) Other	<input type="radio"/>	<input type="radio"/>

Specify: _____

2. In the past 2 years, have you noticed any increase in:

If No, go to next question.
 If Yes, indicate amount of increase.

	No	Yes	<1 in.	1-2 in.	>2 in.
1) Shirt neck size	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Trouser waist size	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3. Have you ever been told by a medical practitioner that you have:

	No	Yes
1) High blood sugar, diabetes, or sugar diabetes?	<input type="radio"/>	<input type="radio"/>
2) High blood cholesterol level?	<input type="radio"/>	<input type="radio"/>
3) High blood triglyceride level?	<input type="radio"/>	<input type="radio"/>
4) High blood pressure?	<input type="radio"/>	<input type="radio"/>

4. Have you taken insulin in the past 2 years?

No Yes (IF "NO", GO TO NEXT PAGE)

5. Are you now taking insulin?

No Yes

LIPODYSTROPHY PHYSICAL EXAMINATION

1. Weight:

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

lbs.

(see instructions)

2. Height:

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

inches

(see instructions)

3. Waist Girth:

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

(see instructions)

4. Hip Girth:

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

(see instructions)

5. Mid-Arm Girth:

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

(see instructions)

6. Thigh Girth

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

(see instructions)

7. Fat Wasting (see severity definitions below):

If None, go to next question. If Yes, indicate severity of symptom.

Severity*
Mild Moderate Severe

- 1) Facial fat loss (sunken cheeks)
- 2) Arms
- 3) Legs
- 4) Buttocks

None	Yes	Mild	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. Fat Accumulation:

If None, go to next question. If Yes, indicate severity of symptom.

Severity*
Mild Moderate Severe

- 1) Moon facies
- 2) Abdomen
- 3) Back of Neck
- 4) Breasts

None	Yes	Mild	Moderate	Severe
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Specify:

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.