MACS

FOLLOW-UP VISIT

Visits 35 - 36

PHYSICAL EXAM

VISIT NUMBER

CLINICIAN NUMBER

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

1. ID NUMBER

2. DATE

JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC

DAY | YR 0 1

3. WEIGHT

POUNDS

4. BLOOD PRESSURE Sitting, Right Arm

SYSTOLIC | DIASTOLIC

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

°F

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

a. Fungal infection lesions (excluding athletes foot)

	NO	YES
§ 1) Intertriginous candida	○	○
§ 2) Tinea versicolor	○	○
§ 3) Onychomycosis	○	○
b. Herpes Zoster (active)	○	○
c. Molluscum contagiosum	○	○
d. Seborrhea	○	○
e. Psoriasis	○	○
f. Jaundice	○	○
g. Spider Angioma	○	○
h. Other (please describe below)	○	○

i. Kaposi's Sarcoma

	NO	YES
§ 1) Skin Lesions	○	○

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
0 1 2 3 4 5 6 7 8 9 cms

	NO	YES
§ 2) Oral lesions	○	○
§ 3) Anal/perianal lesions	○	○

○ Not examined

Comments:

237711

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. Conjuctiva		
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?	◯	◯

b. Presence of node ≥1 cm

		NO	YES
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

	NO	YES
d. Are any of the nodes tender?	◯	◯
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)	

	NO	YES
1. Ascites	○	○
2. Caput Medusa	○	○

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

	NO	YES
Palpable on inspiration below left costal margin	○	○

Size below LCM

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

	NO	YES
c. Other *(please describe below)*	○	○

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

11. ANAL/RECTAL EXAMINATION

	NO	YES
a. Discharge	○	○
§ b. Herpetic lesions	○	○
§ c. Warts	○	○
d. Prostate		
1) Enlarged	○	○
2) Tender	○	○
§ e. Digital exam		
1) Tender anal canal	○	○
f. Hemorrhoids, external	○	○
§ g. Laceration/Fissure/Fistula	○	○
h. Other *(please describe below)*	○	○

○ Mark here if genital exam was declined.

12. GENITALIA

	NO	YES
§ a. Urethral discharge	○	○
b. Testicular atrophy	○	○
§ c. Skin		
1) Condyloma acuminata (warts)	○	○
2) Pediculosis	○	○
3) Tinea cruris/Candida	○	○
4) Herpetic lesions (active)	○	○
Other *(please describe below)*	○	○

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

	NORMAL	ABNORMAL	COMMENTS
General Appearance	○	○	
Chest and Lungs	○	○	
Heart	○	○	
Extremities	○	○	
Neurological Exam	○	○	

237711

14. PERIPHERAL NEUROPATHY SCREENING

	NO	YES
a. Perception of vibration (at great toe)	◯	◯

IF YES: Vibration was felt for: →
- ◯ >10 sec. (normal)
- ◯ 5–10 sec. (mild loss)
- ◯ >0 and <5 sec. (moderate loss)
- ◯ 0 sec. (severe loss)
- ◯ Unable to evaluate

	NO	YES
b. Deep tendon reflexes (ankle reflexes)	◯	◯

IF YES: Reflexes felt were: →
- ◯ Absent
- ◯ Hypoactive
- ◯ Normal deep tendon reflexes
- ◯ Hyperactive deep tendon reflexes (e.g., with prominent spread)
- ◯ Clonus
- ◯ Unable to evaluate

Additional Comments:

LIPODYSTROPHY SELF-REPORT 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.]

◯ 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.		Current Severity			
	No	Yes	None	Mild	Moderate	Severe
1) Facial fat loss (sunken cheeks)	◯	◯	◯	◯	◯	◯
2) Arm fat loss	◯	◯	◯	◯	◯	◯
3) Leg fat loss	◯	◯	◯	◯	◯	◯
4) Buttocks fat loss	◯	◯	◯	◯	◯	◯
5) Belly (abdomen) fat gain	◯	◯	◯	◯	◯	◯
6) Fat pad (hump) on back of neck	◯	◯	◯	◯	◯	◯
7) Breasts fatter	◯	◯	◯	◯	◯	◯
8) Other *(if Yes, specify below)*	◯	◯				

____

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	◯	◯
2) Changing HIV medications	◯	◯
3) Exercise/Weight lifting	◯	◯
4) Taking supplements	◯	◯
5) Taking growth hormone or steroids	◯	◯
6) Liposuction surgery	◯	◯
7) Other *(if Yes, specify below)*	◯	◯

____

2. Since your last visit in [MONTH], have you noticed any change in:

	If No, go to next question. If Yes, indicate if change was an increase or decrease and the amount of change.		*Mark only one*		*Amount of change since your last visit.*		
	No	Yes	Increase	Decrease	<1 in.	1–2 in.	>2 in.
1) Shirt neck size	◯	◯	◯	◯	◯	◯	◯
2) Trouser waist size	◯	◯	◯	◯	◯	◯	◯

3. Since your last visit in [Month], have you been told by a medical practitioner that you have:

	No	Yes
1) High blood cholesterol level?	◯	◯
2) High blood triglyceride level?	◯	◯
3) High blood pressure?	◯	◯

	No	Yes	
4. Since your last visit in [Month], have you been told by a medical practitioner that you have high blood sugar, diabetes, or sugar diabetes?	◯	◯	(IF "NO", GO TO NEXT PAGE)
5. Have you taken insulin since your last visit?	◯	◯	(IF "NO", GO TO NEXT PAGE)
6. Are you now taking insulin?	◯	◯	

237711

LIPODYSTROPHY PHYSICAL EXAMINATION

1. **Weight:** recorded on page 1
2. **Height:** ☐☐ inches (see instructions)
3. **Waist Girth:** ☐☐☐ cm (see instructions)
4. **Hip Girth:** ☐☐☐ cm (see instructions)
5. **Mid-Arm Girth:** ☐☐.☐ cm (see instructions)
6. **Thigh Girth** ☐☐.☐ cm (see instructions)

Each box: ⓪ ① ② ③ ④ ⑤ ⑥ ⑦ ⑧ ⑨

7. Fat Wasting (see severity definitions below):

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

	None	Yes	Severity* Mild	Moderate	Severe
1) Facial fat loss (sunken cheeks)	○	○	○	○	○
2) Arms	○	○	○	○	○
3) Legs	○	○	○	○	○
4) Buttocks	○	○	○	○	○

8. Fat Accumulation:

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

	None	Yes	Severity* Mild	Moderate	Severe
1) Moon facies	○	○	○	○	○
2) Abdomen	○	○	○	○	○
3) Back of Neck	○	○	○	○	○
4) Breasts	○	○	○	○	○

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.

Mark Reflex® by NCS EM-228123C-4:654321 Printed in U.S.A.