MACS

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: ✗ ✓ ⋀⋀⋀ ⊙

1. ID NUMBER | VISIT NUMBER | CLINICIAN NUMBER

2. DATE

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

DAY: 00 10 20 30

YR: 09 10 11 12 13 14 15 16 17 18

3.a HEIGHT cm (see instructions)

3.b WEIGHT KILOGRAMS

4.a

	NO	YES
Did participant refrain from caffeine and nicotine for at least 30 minutes prior to first BP reading?	○	○
Did participant sit quietly for about 5 minutes prior to first BP reading?	○	○
Did participant sit quietly for about 5 minutes prior to second BP reading?	○	○

4.b BLOOD PRESSURE ARM

○ Right ○ Left

FIRST READING — BLOOD PRESSURE Sitting, Right Arm — SYSTOLIC | DIASTOLIC

SECOND READING — BLOOD PRESSURE Sitting, Right Arm — SYSTOLIC | DIASTOLIC

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

SECTION NOT COMPLETED DUE TO:

PAGES 1–4
- ○ Participant refused this section
- ○ No clinician available

PAGES 5–6
- ○ Participant refused lipo section
- ○ No lipo examiner available

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

a. Fungal infection lesions (excluding athletes foot)

	NO	YES	REFUSED
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	REFUSED
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

2) Oral lesions	○	○	○
3) Anal/perianal lesions	○	○	○

○ Not examined

Comments:

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7. OROPHARYNGEAL

	NO	YES	REFUSED
a. Consistent with oral thrush/candidiasis	○	○	○
IF YES:			
○ KOH negative			
-OR-			
○ KOH positive			
○ Not performed			
b. Consistent with herpetic lesions	○	○	○
c. Gingivitis/gum disease	○	○	○
d. Oral hairy leukoplakia	○	○	○
e. Other *(please describe below)*	○	○	○

8. EYES

	NO	YES	REFUSED
a. Conjuctiva			
1) Redness	○	○	○
2) Discharge	○	○	○
b. Scleral icterus	○	○	○
c. Other *(please describe below)*	○	○	○

9. LYMPH NODES

	NO	YES	REFUSED
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

	NO	YES
d. Are any of the nodes tender?	○	○
e. Are any of the nodes matted?	○	○

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10. ABDOMEN

a. Liver — REFUSED

Percussed size in mid-clavicular line

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

	NO	YES	REFUSED
1. Ascites			

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

	NO	YES	REFUSED
Palpable on inspiration below left costal margin			

IF PALPABLE, indicate size. Otherwise, leave size box blank.

Size below LCM

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

c. Other conditions *(please describe)* — NO YES REFUSED

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:

1. Collect cytology swab	No	Yes
2. Collect HPV swab	No	Yes
3. Perform annual rectal exam, including digital	No	Yes

11. ANAL/RECTAL EXAMINATION

	NO	YES	REFUSED
a. Anal swab collected for:			
1) Cytology test			
2) HPV test			
b. Visual exam			
1) Discharge			
2) Herpetic lesions			
3) Warts			
4) Hemorrhoids, external			
5) Laceration/fissure/fistula			
c. Digital exam			
1) Tender anal canal			
2) Prostate			
2.a) enlarged			
2.b) tender			
d. Other conditions *(please describe below)*			

12. GENITALIA

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

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

	NORMAL	ABNORMAL	NOT PERFORMED	COMMENTS
General Appearance				
Chest and Lungs				
Heart				
Extremities				
Neurological Exam				

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14. PERIPHERAL NEUROPATHY SCREENING (See training video at *http://www.calcaprt.com/macs/macs.htm*).

RIGHT

a1. Perception of vibration (at great toe)
(Use a 128 Hz tuning fork)

- ◯ NO, sensation absent
- ◯ YES, sensation present
- ◯ Unable to evaluate
- ◯ REFUSED

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

LEFT

a2. Perception of vibration (at great toe)
(Use a 128 Hz tuning fork)

- ◯ NO, sensation absent
- ◯ YES, sensation present
- ◯ Unable to evaluate
- ◯ REFUSED

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

RIGHT

b1. Deep tendon reflexes (ankle reflexes)

- ◯ NO, reflexes absent
- ◯ YES, reflexes present
- ◯ Unable to evaluate
- ◯ REFUSED

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

LEFT

b2. Deep tendon reflexes (ankle reflexes)

- ◯ NO, reflexes absent
- ◯ YES, reflexes present
- ◯ Unable to evaluate
- ◯ REFUSED

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

Additional Comments:

LIPODYSTROPHY 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 PAGE 6)
- ◯ YES
- ◯ REFUSED (IF "REFUSED", SKIP TO PAGE 6)

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

[ASK EACH ITEM AND RECORD ANSWER]

If No or Refused, go to next question. If Yes, indicate type of change and severity of symptom.

Was this change an increase or decrease? →

	Refused	No	Yes	Increase	Decrease	Current Severity: None	Mild	Moderate	Severe
1) Facial fat	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
2) Arm fat	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
3) Leg fat	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
4) Buttocks fat	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
5) Belly (abdomen) fat	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
6) Fat on back of neck	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
7) Breasts	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
8) Hips	◯	◯	◯ →	◯	◯	◯	◯	◯	◯
9) 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	Refused
1) Changing diet	◯	◯	◯
2) Changing HIV medications	◯	◯	◯
3) Exercise/Weight lifting	◯	◯	◯
4) Taking nutritional supplements	◯	◯	◯
5) Taking growth hormone or steroids	◯	◯	◯
6) Liposuction surgery	◯	◯	◯
7) Cheek implants/injections	◯	◯	◯
8) Other cosmetic surgery	◯	◯	◯
9) Other *(if Yes, specify below)*	◯	◯	◯

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

If No or Refused, go to next question. If Yes, indicate if change was an increase or decrease and the amount of change.

Was this change an increase or decrease? →

Amount of change since your last visit.

	Refused	No	Yes	Increase	Decrease	<1 in.	1–2 in.	>2 in.
1) Shirt neck size?	◯	◯	◯ →	◯	◯	◯	◯	◯
2) Trouser waist size?	◯	◯	◯ →	◯	◯	◯	◯	◯

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LIPODYSTROPHY PHYSICAL EXAMINATION

1. Neck Girth:

(see instructions)

2. Waist Girth:

(see instructions)

3. Hip Girth:

(see instructions)

4. Thigh Girth

(see instructions)

LIPODYSTROPHY MEASURER CODE

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