WOMEN'S INTERAGENCY HIV STUDY
FOLLOW-UP VISIT
ABSTRACT TRACKING CHECKLIST

AFFIX ID LABEL HERE --->

A1. PARTICIPANT ID: |__| - |__|__| - |__|__|__|__| - |__|

A2. WIHS STUDY VISIT #: ___ ___

A3. FORM VERSION: 0 2 / 0 1 / 9 7

A4. FORM COMPLETED BY: ___ ___ ___

A5. HAS THE PARTICIPANT SIGNED A MEDICAL RECORD RELEASE?

YES..1
NO..2

INSTRUCTIONS: USE AS A CHECKLIST TO INDICATE WHERE TO COLLECT FURTHER INFORMATION FOR MEDICAL RECORD ABSTRACTION.

FORM 22 - MEDICAL AND HEALTH HISTORY

	a. QUESTION NUMBER		b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
O	C1 -	CANCER	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C2 -	CERVICAL CANCER	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C3 -	KAPOSI'S SARCOMA	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C4 -	LYMPHOMA	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C5 -	LYMPHOMA BRAIN	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C6 -	HODGKINS DISEASE	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C7 -	BREAST CANCER	___ ___ / ___ ___ / ___ ___ (M D Y)	
O	C8 -	CANCER OF THE OVARY/OVARIES	___ ___ / ___ ___ / ___ ___ (M D Y)	

WIHS ID#

	a. QUESTION NUMBER		b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
O	C9 -	CANCER OF THE UTERUS	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C10 -	SKIN CANCER	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C11 -	OTHER CANCER	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29 -	TB	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29a -	TB IN LUNGS	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29b -	TB IN BLOOD	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29c -	TB IN LYMPH NODES	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29d -	TB IN OTHER PART OF THE BODY	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29e -	Rx RECEIVED FOR TB	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C29f -	MEDS TAKEN FOR TB	____ _____ / ____ ____ / ___ ____ (M D Y)	
O	C30b -	POSITIVE TB SKIN TEST	____ _____ / ____ ____ / ___ ____ (M D Y)	
..	D1 -	SHINGLES	____ _____ / ____ ____ / ___ ____ (M D Y)	
..	D3-	THRUSH	____ _____ / ____ ____ / ___ ____ (M D Y)	
..	E1 -	CD4<200 OR 14%	____ _____ / ____ ____ / ___ ____ (M D Y)	

WIHS ID#

a. QUESTION NUMBER		b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
•• E2 -	PCP	____ ____ / ____ ____ / ____ ____ M D Y	
•• E3 -	OTHER TYPE PNEUMONIA	____ ____ / ____ ____ / ____ ____ M D Y	
•• E4 -	CANDIDA/THRUSH ESOPHAGUS	____ ____ / ____ ____ / ____ ____ M D Y	
•• E5 -	CANDIDA/THRUSH TRACH/BRONCHI	____ ____ / ____ ____ / ____ ____ M D Y	
•• E6 -	MAI/MAC	____ ____ / ____ ____ / ____ ____ M D Y	
•• E7 -	TOXO INFECTION	____ ____ / ____ ____ / ____ ____ M D Y	
•• E8 -	CMV RETINITIS	____ ____ / ____ ____ / ____ ____ M D Y	
•• E9 -	CMV/ELSEWHERE IN BODY	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10 -	SEVERE DIARRHEA	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10ai -	CRYPTOSPORIDIA	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10aii -	MICROSPORIDIA	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10aiii -	ISOSPORA	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10aiv -	CMV	____ ____ / ____ ____ / ____ ____ M D Y	
•• E10av -	MAI	____ ____ / ____ ____ / ____ ____ M D Y	

WIHS ID#

a. QUESTION NUMBER			b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
••	E11 -	MENINGITIS	____ _____ / ____ ____ / ___ ____ M D Y	
••	E11a -	CRYPTO MENINGITIS	____ _____ / ____ ____ / ___ ____ M D Y	
••	E12 -	CRYPTO IN BLOOD OR ELSEWHERE	____ _____ / ____ ____ / ___ ____ M D Y	
••	E13 -	HISTOPLASMOSIS	____ _____ / ____ ____ / ___ ____ M D Y	
••	E14 -	COCCI	____ _____ / ____ ____ / ___ ____ M D Y	
••	E15 -	WASTING SYNDROME	____ _____ / ____ ____ / ___ ____ M D Y	
••	E16 -	DEMENTIA/ ENCEPHALOPATHY	____ _____ / ____ ____ / ___ ____ M D Y	
••	E17 -	HERPES/ULCERS>1 MONTH	____ _____ / ____ ____ / ___ ____ M D Y	
••	E18 -	HERPES SIMPLEX OF LUNGS	____ _____ / ____ ____ / ___ ____ M D Y	
••	E19 -	SALMONELLA	____ _____ / ____ ____ / ___ ____ M D Y	
O	E20 -	PML	____ _____ / ____ ____ / ___ ____ M D Y	
••	E21 -	AIDS	____ _____ / ____ ____ / ___ ____ M D Y	
••	E23 -	BIOPSY	____ _____ / ____ ____ / ___ ____ M D Y	
••	E23a -	LUNG BIOPSY	____ _____ / ____ ____ / ___ ____ M D Y	

WIHS ID#

a. QUESTION NUMBER	b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
•• E23b - SKIN BIOPSY	____ ____ / ____ ____ / ____ ____ M D Y	
•• E23c - BONE MARROW BIOPSY	____ ____ / ____ ____ / ____ ____ M D Y	
•• E23d - OTHER BIOPSY	____ ____ / ____ ____ / ____ ____ M D Y	

E24a. # of Hospitalizations: ______

a. QUESTION NUMBER	b. DATE OF EVENT SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
•• E24i - HOSPITALIZATION (1)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24ii - HOSPITALIZATION (2)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24iii - HOSPITALIZATION (3)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24iv - HOSPITALIZATION (4)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24v - HOSPITALIZATION (5)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24vi - HOSPITALIZATION (6)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24vii - HOSPITALIZATION (7)	____ ____ / ____ ____ / ____ ____ M D Y	
•• E24viii - HOSPITALIZATION (8)	____ ____ / ____ ____ / ____ ____ M D Y	

WIHS ID#

FORM 23 - OBSTETRICS, GYNECOLOGY, AND CONTRACEPTIVE HISTORY

a. QUESTION NUMBER		b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
•• B7 -	GYN SURGERY	____ ____ / ____ ____ / ____ ____ M D Y	
•• B10 -	HYSTERECTOMY	____ ____ / ____ ____ / ____ ____ M D Y	
•• D3 -	Rx FOR CERVICAL OR OTHER ABNORMALITY	____ ____ / ____ ____ / ____ ____ M D Y	
•• E4 -	PID	____ ____ / ____ ____ / ____ ____ M D Y	
•• E9 -	VAGINAL CANDIDA	____ ____ / ____ ____ / ____ ____ M D Y	
•• F8 -	BREAST BIOPSY	____ ____ / ____ ____ / ____ ____ M D Y	