WOMEN'S INTERAGENCY HIV STUDY
BASELINE VISIT
ABSTRACT TRACKING CHECKLIST

AFFIX ID LABEL HERE --->

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

A2. WIHS STUDY VISIT #: ___ ___

A3. FORM VERSION: 0 8 / 1 5 / 9 4

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.

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION

FORM 2 - MEDICAL AND HEALTH HISTORY

☐	C1 - CANCER	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____
☐	C2. - CERVICAL CANCER	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____
☐	C3 - KAPOSI'S SARCOMA	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____
☐	C4 -LYMPHOMA	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____
☐	C5 - LYMPHOMA BRAIN	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____
☐	C6 -HODGKINS DISEASE	___ ___ / ___ ___ / ___ ___ (M D Y)	_____ _____ _____

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION
☐ C7 - BREAST CANCER	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C8 - OVARIAN CANCER	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C9 - ENDOMETRIAL CANCER	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C10 - SKIN CANCER	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C11 - OTHER CANCER	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C16 - TB	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C16a - TB IN LUNGS	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C16b - TB OTHR PART OF THE BODY	___ ___ / ___ ___ / ___ ___ (M / D / Y)	
☐ C17 TB SKIN TEST	___ ___ / ___ ___ / ___ ___ (M / D / Y)	

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION
☐ E1 - CD4 < 200 OR 14%	___ ___ / ___ ___ / ___ ___ M D Y	
☐ 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 - CRYPTOSPOR-IDIA	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E10aii - MICROSPOR -		

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION
IDIA	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E10aiii - ISOSPORA	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E10aiv - CMV	___ ___ / ___ ___ / ___ ___ M D Y	

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION
☐ E10av - MAI	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E11 - CRYPTO MENINGITIS	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E12 - CRYPTO IN BODY	___ ___ / ___ ___ / ___ ___ 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	
☐ E20 - PML	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E21 - AIDS		

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION
	___ ___ / ___ ___ / ___ ___ M D Y	
☐ E22i - HOSPITALIZATION (1)	___ ___ / ___ ___ / ___ ___ M D Y	
E22ii - HOSPITALIZATION (2)	___ ___ / ___ ___ / ___ ___ M D Y	
E22iii - HOSPITALIZATION (3)	___ ___ / ___ ___ / ___ ___ M D Y	
E22iv - HOSPITALIZATION (4)	___ ___ / ___ ___ / ___ ___ M D Y	
E22v - HOSPITALIZATION (5)	___ ___ / ___ ___ / ___ ___ M D Y	
E22vi - HOSPITALIZATION (6)	___ ___ / ___ ___ / ___ ___ M D Y	
E22vii - HOSPITALIZATION (7)	___ ___ / ___ ___ / ___ ___ M D Y	
E22viii - HOSPITALIZATION (8)	___ ___ / ___ ___ / ___ ___ M D Y	

WIHS ID#

a. FORM & QUESTION NUMBER (S)	b. DATE OF FIRST DIAGNOSIS	c. NAME AND ADDRESS OF THE INSTITUTION

FORM 3 - OBSTETRICS, GYNECOLOGY, AND CONTRACEPTIVE HISTORY

☐ B17c - CANCER - REASON HYSTERECTOMY ___ ___ / ___ ___ / ___ ___ (M / D / Y)

☐ F8c - BREAST CANCER ___ ___ / ___ ___ / ___ ___ (M / D / Y)

FORM 7 - PHYSICAL EXAM

☐ E9 - MASTECTOMY ___ ___ / ___ ___ / ___ ___ (M / D / Y)