

A5. INDICATION FOR TREATMENT (Circle the most severe lesion for each)

- a. Cervical
 - None 1
 - Exophytic condyloma..... 2
 - LG SIL: HPV 3
 - LG SIL: CIN1 (Mild dysplasia) 4
 - LG SIL: Unspecified 5
 - HG SIL: CIN II (Mod dysplasia) 6
 - HG SIL: CIN III (Severe/CIS) 7
 - Microinvasive CA 8
 - Invasive CA..... 9
 - Adenocarcinoma - in - situ10
 - Adenocarcinoma..... 11
 - Other..... 12

(SPECIFY)

- b. Vaginal
 - None 1
 - HPV lesion 2
 - VAIN I 3
 - VAIN II 4
 - VAIN III..... 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

- c. Vulvar
 - None 1
 - HPV lesion 2
 - VIN I 3
 - VIN II 4
 - VIN III..... 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

- d. Perianal
 - None 1
 - HPV lesion 2
 - PAIN I 3
 - PAIN II..... 4
 - PAIN III 5
 - Invasive CA..... 6
 - Other..... 7

(SPECIFY)

WIHS ID #

- e. Anal
 - None 1
 - HPV lesion 2
 - AIN I 3
 - AIN II 4
 - AIN III 5
 - Invasive CA 6
 - Other 7

(SPECIFY)

- f. Endometrium
 - None 1
 - Atypical hyperplasia 2
 - Invasive CA 3
 - Other 4

(SPECIFY)

- g. Other Location:
 - Yes 1
 - No 2(A6)

i. Location

(SPECIFY)

ii. Lesion

(SPECIFY)

**A6. INDICATION FOR TREATMENT BASED ON:
(circle yes or no for each indication)**

	<u>YES</u>	<u>NO</u>
a. Suspicious pap smear with inadequate colposcopy 1	1	2
b. Histologic diagnosis 1	1	2
c. Pap smear - histologic - colposcopic discrepancy 1	1	2
d. Abnormal colposcopy 1	1	2
e. Grossly apparent lesion 1	1	2
f. Other 1	1	2

(SPECIFY)

WIHS ID #

A7. TREATMENT MODALITY:

a. Cervix (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1(b)	2
2. Interferon	1	2
3. 5 - FU	1	2
4. Cryotherapy	1	2
5. Laser vaporization	1	2
6. Laser conization	1	2
7. LEEP/LLETZ (transformation zone)	1	2
8. LEEP conization	1	2
9. Cold - knife conization	1	2
10. Hysterectomy (simple)	1	2
11. Hysterectomy (radical)	1	2
12. Radiation therapy	1	2
13. Other	1	2

(SPECIFY)

b. Vagina (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1 (c)	2
2. TCA	1	2
3. Podophyllin	1	2
4. Condylox	1	2
5. Interferon	1	2
6. 5 - FU	1	2
7. Cryotherapy	1	2
8. Laser vaporization	1	2
9. LEEP	1	2
10. Vaginal excision (local)	1	2
11. Vaginectomy	1	2
12. Radiation therapy	1	2
13. Other	1	2

(SPECIFY)

c. Vulva (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1 (d)	2
2. TCA	1	2
3. Podophyllin.....	1	2
4. Condylox	1	2
5. Interferon	1	2
6. 5 - FU.....	1	2
7. Cryotherapy	1	2
8. Laser vaporization	1	2
9. LEEP.....	1	2
10. Wide local excision.....	1	2
11. Vulvectomy.....	1	2
12. Radiation therapy.....	1	2
13. Other	1	2

(SPECIFY)

d. Perianal (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1 (e)	2
2. TCA	1	2
3. Podophyllin.....	1	2
4. Condylox	1	2
5. Interferon	1	2
6. 5 - FU.....	1	2
7. Cryotherapy	1	2
8. Laser vaporization	1	2
9. LEEP.....	1	2
10. Excision	1	2
11. Radiation therapy.....	1	2
12. Other	1	2

(SPECIFY)

e. Anal (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1 (f)	2
2. TCA	1	2
3. Podophyllin.....	1	2
4. Condylox	1	2
5. Interferon	1	2
6. 5 - FU.....	1	2
7. Cryotherapy	1	2
8. Laser vaporization	1	2
9. LEEP.....	1	2
10. Excision	1	2
11. Radiation therapy.....	1	2
12. Other	1	2

(SPECIFY)

f. Endometrium (circle yes or no for each modality)

	<u>YES</u>	<u>NO</u>
1. None/Observation	1 (g)	2
2. Hormone therapy	1	2
3. Dilation and Curettage (D&C).....	1	2
4. Hysterectomy (simple).....	1	2
5. Hysterectomy (radical)	1	2
6. Radiation therapy.....	1	2
7. Other	1	2

(SPECIFY)

g. Other Location:

Yes.....1
No.....2(A8)

i. Location:

(SPECIFY)

ii. Modality

(SPECIFY)

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A8. IS THIS PATIENT PART OF ANOTHER STUDY EVALUATION FOR TREATMENT OF DYSPLASIA?

YES 1
NO 2 (A9)

a. SPECIFY NAME OF STUDY: _____

b. SPECIFY NAME OF STUDY SITE: _____

A9. WAS HISTOLOGIC EVALUATION OBTAINED OR BIOPSY PERFORMED DURING THIS TREATMENT PROCEDURE ?

YES 1 (Complete Form L15 for each biopsy performed)
NO 2

A10. FOLLOW UP SCHEDULED?

YES 1
NO 2 (A11)
UNKNOWN.....<-8> (A11)

a. INDICATE SCHEDULED FOLLOW-UP IN WEEKS OR MONTHS:

 |_|_| WEEKS..... 1
 MONTHS..... 2

b. INDICATE TYPE OF FOLLOW-UP PLANNED:

Repeat pap only1
Repeat pap & colposcopy.....2
Repeat colposcopy only3
Repeat treatment.....4
Other5

(SPECIFY)

A11. WAS TREATMENT COMPLETED TODAY?

YES, Complete 1
NO, Incomplete 2
Ongoing 3
Delayed 4
Other 5

(SPECIFY)

Refused <-7>
Unknown <-8>

WIHS ID #

A12. HOW WAS THIS INFORMATION OBTAINED?
(circle yes or no for each source)

	<u>YES</u>	<u>NO</u>
a. Study personnel	1	2
b. Chart abstraction	1	2
c. Direct contact with provider	1	2
d. Patient history	1	2
e. Other	1	2

(SPECIFY)

A13. INDICATE PRIMARY SOURCE OF THIS INFORMATION?
(code below even if only one source = yes at A12)

	<u>YES</u>	<u>NO</u>
a. Study personnel	1	2
b. Chart abstraction	1	2
c. Direct contact with provider	1	2
d. Patient history	1	2
e. Other	1	2

(SPECIFY)

A14. Name of person providing treatment on this date:

(Please Print)

A15. Institution (Name or Number):
(Please Print)

(ADDRESS)