



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 - situ .....10
  - Adenocarcinoma ..... 11
  - Other..... 12

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**(SPECIFY)**

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

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**(SPECIFY)**

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

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**(SPECIFY)**

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

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**(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	2
b. Histologic diagnosis .....	1	2
c. Pap smear - histologic - colposcopic discrepancy.....	1	2
d. Abnormal colposcopy .....	1	2
e. Grossly apparent lesion.....	1	2
f. Other.....	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

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**(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

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**(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)

WIHS ID #

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 only .....1  
Repeat pap & colposcopy .....2  
Repeat colposcopy only .....3  
Repeat treatment .....4  
Other .....5

\_\_\_\_\_  
(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)