WOMEN'S INTERAGENCY HIV STUDY
ORAL PROTOCOL MEDICAL EVALUATION
FORM OP1

GENERAL INFORMATION

PARTICIPANT ID: ENTER NUMBER HERE ONLY IF ID LABEL IS NOT AVAILABLE

|__|- |__|__| - |__|__|__|__| - |__|

WIHS STUDY VISIT NUMBER: __ __

FORM VERSION: 1 0 / 0 1 / 9 8
M D Y

DATE OF INTERVIEW: __ __ / __ __ / __ __
M D Y

INTERVIEWER'S INITIALS: __ __ __

TIME ORAL VISIT BEGAN: |__|__| : |__|__| AM 1
PM 2

INTRODUCTION: READ TO PARTICIPANT

Thank you for agreeing to participate in the oral component of the WIHS study. This is a very important aspect of the WIHS study because we will learn more about women's oral health. I will need to ask you a few questions about your medical history and oral hygiene. I understand that some of these questions may be difficult for you to answer. Please take as much time as you need so I can gather information which is as accurate as possible. Of course your responses will be kept confidential. Your name will not be reported to anyone, or recorded on any form. We will use the same unique identification number that is used for the rest of the study.

WIHS ID #

QUESTIONNAIRE

1. Does the participant have a history of any of the following medical conditions requiring antibiotic prophylaxis for dental treatment:

		YES	NO	DON'T KNOW
a.	Artificial heart valves?	1	2	<-8>
b.	Surgically constructed heart-lung artificial channel or passage?	1	2	<-8>
c.	Heart malformations since birth?	1	2	<-8>
d.	Rheumatic or heart valve disease?	1	2	<-8>
e.	Enlarged heart?	1	2	<-8>
f.	Mitral valve prolapse (MVP)with a leaky valve?	1	2	<-8>
g.	Heart valve surgery?	1	2	<-8>
h.	Existing catheter in your bloodstream?	1	2	<-8>
i.	Previous infective endocarditis?	1	2	<-8>
j.	Localized narrowing of the heart valve since birth?	1	2	<-8>
k.	Kidney dialysis with an A-V shunt?	1	2	<-8>

2. Are prophylactic antibiotics indicated?

YES.....1
NO.....2 **(5)**

3. Is participant currently on an antibiotic regimen equivalent to that required for dental prophylaxis?

YES.....1 **(5)**
NO.....2

4. a. Are prophylactic antibiotics being administered specifically for this oral examination?

WIHS ID #

YES.....1 **(4b)**
NO.....2

_____ **(5)**
SPECIFY REASON

b. What is being administered?

		YES	NO
i.	Amoxicillin 2.0g orally one hour before procedure?	1	2
ii.	Clindamycin 600 mg orally one hour before procedure?	1	2
iii.	Other?	1	2

_____
_____

5. Any change(s) in any medications since the last WIHS visit (ie. the core WIHS visit which occurred within the last 2 weeks)?

YES.....1
NO.....2 **(6)**

a. What change(s)? _____

6. Any treatments for oral lesions identified at the last WIHS visit (i.e. the core visit which occurred in the last 2 weeks)?

YES.....1
NO.....2 **(7)**

a. What treatments? _____

7. Any hospitalizations, clinic or doctor's office visit since last WIHS visit (ie. the core WIHS visit which occurred within the last 2 weeks)?

YES.....1
NO.....2 **(8)**

a. What for? _____

8. Where does participant usually go for dental care?

a. Dental Care Provider: _____

Address: _____

b. When was your last dental visit? _____

c. What did you see the dentist for? _____