FOLLOW-UP VISIT
PHYSICAL EXAM

MARKING INSTRUCTIONS
• Make dark marks that fill the circle completely.
• Make clean erasures.
• Make NO stray marks.
• Do NOT fold this form.

1. ID NUMBER
   JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC
   0 0 0 0 0 0 0 0 0 0 0 0

2. DATE
   JAN FEB MAR APR MAY JUNE JULY AUG SEPT OCT NOV DEC
   00 01 02 03 04 05 06 07 08 09

3. WEIGHT
   0 0 0 0 0 0 0 0 0 0

4. BLOOD PRESSURE
   Sitting, Right Arm
   0 0 0 0 0 0 0 0 0 0

5. ORAL TEMPERATURE
   At least 30 minutes after smoking, eating, or drinking
   0 0 0 0 0 0 0 0 0 0

6. SKIN/HAIR/NAILS (Excluding genital area)
   a. Fungal infection lesions (excluding athlete's foot)
      1) Intertriginous candida
      2) Tinea versicolor
      3) Onychomycosis
   b. Herpes Zoster (active)
   c. Molluscum contagiosum
   d. Seborrhea
   e. Psoriasis
   f. Jaundice
   g. Spider Angioma
   h. Other (please describe below)

i. Kaposi's Sarcoma
   NO YES
   1) Skin Lesions
      IF YES: Number of lesions
      1-2 3-10 >10
      Diameter of largest lesion in cms.
      0 0 0 0 0 0 0 0 0 0
   2) Oral lesions
   3) Anal/perianal lesions
      Not examined

   Comments:
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
   ______________________________________________________
7. OROPHARYNGEAL
   a. Consistent with oral thrush/candidiasis
      • NO
      • YES
      
      IF YES:
      • KOH negative
      • OR:
      • KOH positive
      • Not performed
   b. Consistent with herpetic lesions
   c. Gingivitis/gum disease
   d. Oral hairy leukoplakia
   e. Other (please describe below)

8. EYES
   a. Conjuctiva
      1) Redness
      2) Discharge
   b. Scleral icterus
   c. Other (please describe below)

9. LYMPH NODES
   a. Are there any nodes present (excluding inguinal and femoral) which are ≥1 cm?
      • NO
      • YES
      SKIP TO Q 10
   b. Presence of node ≥1 cm
      1) Occipital
         • Right
         • Left
      2) Post. auricular
        • Right
        • Left
      3) Pre-auricular
        • Right
        • Left
      4) Submental/submandibular
        • Right
        • Left
      5) Ant. cervical
        • Right
        • Left
      6) Post. cervical
        • Right
        • Left
      7) Supraclavicular
        • Right
        • Left
      8) Axillary
        • Right
        • Left
      9) Epitrochlear
        • Right
        • Left
   c. What is the diameter of the largest node present?
      • 1–2 cm
      • 2.1–4 cm
      • >4 cm
   d. Are any of the nodes tender?
   e. Are any of the nodes matted?
   
   d. Oral hairy leukoplakia
   e. Other (please describe below)
### 10. ABDOMEN

a. Liver
   - Percussed size in mid-clavicular line
   - Size below LCM

b. Spleen (Rt. lateral decubitus, flexed knees/hips)
   - Palpable on inspiration below left costal margin
   - Size below LCM

c. Other (please describe below)

### 11. ANAL/RECTAL EXAMINATION

- Mark here if either entire rectal exam was declined or sections d) and e).
- Mark here if genital exam was declined.

### 12. GENITALIA

- a. Urethral discharge
- b. Testicular atrophy
- c. Skin
  1. Condyloma acuminata (warts)
  2. Pediculosis
  3. Tinea cruris/Candida
  4. Herpetic lesions (active)
- Other (please describe below)

### 13. EXAMINER’S IMPRESSIONS (use back of page if necessary)

<table>
<thead>
<tr>
<th></th>
<th>NORMAL</th>
<th>ABNORMAL</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Appearance</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Chest and Lungs</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Heart</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Extremities</td>
<td>0</td>
<td>0</td>
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</tr>
<tr>
<td>Neurological Exam</td>
<td>0</td>
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</table>
### 14. PERIPHERAL NEUROPATHY SCREENING

#### RIGHT

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a1. Perception of vibration (at great toe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF YES: Vibration was felt for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;10 sec. (normal)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>5–10 sec. (mild loss)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>&gt;0 and &lt;5 sec. (moderate loss)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>0 sec. (severe loss)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to evaluate</td>
<td></td>
</tr>
</tbody>
</table>

#### LEFT

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>a2. Perception of vibration (at great toe)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF YES: Vibration was felt for:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td></td>
<td>Unable to evaluate</td>
<td></td>
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</table>

#### RIGHT

<table>
<thead>
<tr>
<th></th>
<th>NO, reflexes absent</th>
<th>YES, reflexes present</th>
</tr>
</thead>
<tbody>
<tr>
<td>b1. Deep tendon reflexes (ankle reflexes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF YES: Reflexes felt were:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hypoactive</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Normal deep tendon reflexes</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Hyperactive deep tendon reflexes (e.g., with prominent spread)</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Clonus</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unable to evaluate</td>
<td></td>
</tr>
</tbody>
</table>

#### LEFT

<table>
<thead>
<tr>
<th></th>
<th>NO, reflexes absent</th>
<th>YES, reflexes present</th>
</tr>
</thead>
<tbody>
<tr>
<td>b2. Deep tendon reflexes (ankle reflexes)</td>
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<td></td>
</tr>
<tr>
<td>IF YES: Reflexes felt were:</td>
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<td></td>
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<tr>
<td></td>
<td>Unable to evaluate</td>
<td></td>
</tr>
</tbody>
</table>

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**Additional Comments:**

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LIPODYSTROPHY SELF-REPORT QUESTIONNAIRE

1a. Since your last visit in [MONTH], have you noticed any changes in the distribution or in the amount of your body fat (either loss or gain)? [Changes include first time occurrences and increases or decreases in severity since your last visit.]

- NO
- YES

(IF "NO", SKIP TO QUESTION 3)

1b. If "yes" which parts of your body were affected, and how severely?

[ASK EACH ITEM AND RECORD ANSWER]

- Facial fat
- Arm fat
- Leg fat
- Buttocks fat
- Belly (abdomen) fat
- Fat on back of neck
- Breasts
- Waist
- Hips
- Other (if Yes, specify below)

1c. Since you’ve noticed these changes, have you taken actions that would influence your fat distribution such as:

[ASK EACH ITEM AND RECORD ANSWER]

- Changing diet
- Changing HIV medications
- Exercise/Weight lifting
- Taking nutritional supplements
- Taking growth hormone or steroids
- Liposuction surgery
- Cheek implants/injections
- Other cosmetic surgery
- Other (if Yes, specify below)

2. Since your last visit in [MONTH], have you noticed any change in:

- Shirt neck size?
- Trouser waist size?

3. Since your last visit in [Month], have you been told by a medical practitioner that you have: (We mean a new diagnosis or an uncontrolled condition.)

- High blood cholesterol level?
- High blood triglyceride level?
- High blood pressure?

4. Since your last visit in [Month], have you been told by a medical practitioner that you have high blood sugar, diabetes, or sugar diabetes? (We mean a new diagnosis or an uncontrolled condition.)

5. Have you taken insulin since your last visit?

6. Are you now taking insulin?

Serial #
LIPODYSTROPHY PHYSICAL EXAMINATION

1. Height: 

2. Chest Girth: cm 

3. Waist Girth: cm 

4. Hip Girth: cm 

5. Mid-Arm Girth: cm 

6. Thigh Girth: cm 

7. Fat Wasting (see severity definitions below): If None, go to next question. If Yes, indicate severity of symptom. 

   None  Yes  Severity* 

   1) Facial fat loss (sunken cheeks)  
   2) Arms  
   3) Legs  
   4) Buttocks  

8. Fat Accumulation: If None, go to next question. If Yes, indicate severity of symptom. 

   None  Yes  Severity* 

   1) Moon facies  
   2) Abdomen  
   3) Back of Neck  
   4) Breasts  

9. Other physical exam findings noted related to fat distribution: Specify:  

* Definitions:  

None: Patient does not exhibit any signs of fat maldistribution. (Not noted by patient or clinician)  

Mild: Mild signs noted only after close inspection by patient or clinician.  

Moderate: Signs of fat maldistribution are noticed by patient or clinician without specifically looking for it. Patient may complain that current clothing has become tighter.  

Severe: Signs of fat maldistribution easily noted by casual observer. Symptoms have required a change in size of clothing or undergarments worn.
Cuestionario
Auto-informe de Lipodistrofía

1a. Desde su última visita en [MES], ¿ha notado cambios en la distribución o en la cantidad de grasa en su cuerpo (tanto, pérdida como aumento de grasa)? [Estos cambios se refieren a la primera vez que ocurrieron y el nivel de gravedad durante estos últimos dos años.]

☐ No  ☑ Sí  
(IF “NO”, SKIP TO QUESTION 3)

1b. Si contestó que “Sí” a la primera pregunta, ¿cuáles partes de su cuerpo fueron afectadas y cuán grave fue?

[ASK EACH ITEM AND RECORD ANSWER]  
If No, go to next question.  
If Yes, indicate tipo de cambio y gravedad del cambio  
¿Fué este cambio aumento o pérdida?

Gravedad del cambio

<table>
<thead>
<tr>
<th>Cambio</th>
<th>Aumento</th>
<th>Pérdida</th>
<th>Alguna</th>
<th>Moderada</th>
<th>Severa</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>☐</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Sí</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

1c. Desde qué notó estos cambios, ¿ha hecho usted algo para influir en la distribución de grasa en su cuerpo? Por ejemplo:

[ASK EACH ITEM AND RECORD ANSWER]  
1) Cambiar la dieta  
2) Cambiar los medicamentos contra el VIH  
3) Hacer ejercicios/levantamiento de pesas  
4) Tomar suplementos nutritivos  
5) Tomar hormonas de crecimiento o esteroides  

[ASK EACH ITEM AND RECORD ANSWER]

1) Cambiar la dieta  
2) Cambiar los medicamentos contra el VIH  
3) Hacer ejercicios/levantamiento de pesas  
4) Tomar suplementos nutritivos  
5) Tomar hormonas de crecimiento o esteroides  

2. Desde su última visita en [MES], ¿ha notado cambio en:

If No, go to next question.  
If Yes, indicate if change was an increase or decrease and the amount of change.

Mark only one

<table>
<thead>
<tr>
<th>Tamaño del cambio</th>
<th>Aumento</th>
<th>Pérdida</th>
<th>&lt;1 in.</th>
<th>1–2 in.</th>
<th>&gt;2 in.</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>☐</td>
<td>☑</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sí</td>
<td>☑</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

3. Desde su última visita en [MES], ¿le ha dicho su médico que usted tiene:

<table>
<thead>
<tr>
<th>Condición</th>
<th>No</th>
<th>Sí</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Nivel alto de colesterol en la sangre?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>2) Niveles altos de triglicéridos en la sangre?</td>
<td>☐</td>
<td>☑</td>
</tr>
<tr>
<td>3) Presión sanguínea alta?</td>
<td>☐</td>
<td>☑</td>
</tr>
</tbody>
</table>

4. Desde su última visita en [MES], ¿le ha dicho su médico que usted tiene alto nivel de azúcar en la sangre, o diabetes, o diabetes de azúcar?

(IF “NO”, GO TO NEXT PAGE)

5. ¿Ha tomado insulina desde su última visita?

(IF “NO”, GO TO NEXT PAGE)

6. ¿Está tomando insulina actualmente?

SERIAL #