INFECTIOUS DISEASES HASA COHORT ADULT
Follow-Up Clinical Evaluation

Section A: Patient Information	
1. Cohort Study Interval (Enter in weeks) _____	
2. IDC#	3. Cohort Number (X0-nnn)
4. Date of Visit ____/____/_____ DD/MM/YYYY	5. Enrolled in other studies? ☐ Yes ☐ No If Yes, Note here: _____

Section B: Demographics			
1. Surname	2. First Name	3. Initial	4. Phone contact
5. Treatment buddy	6. Relationship with Patient		7. Phone contact

Section C: Vital Signs					Muscle mass	
1. Temp (°C)	2. HR (b/m)	3. BP (mmHg)	4. RR (b/m)	5. Weight (kg)	Skinfold thickness	Limb circumferences

Section D: Current Clinical Status/Therapy

1. Has the patient experienced a clinical event since the last cohort visit?
Code _____

2. Has the patient been diagnosed with any of the following since last cohort visit?

Intercurrent illness	Yes	No	Duration		Intercurrent illness	Yes	No	Duration
Oro-Pharyngeal Candidiasis					Esophageal Candidiasis			
Toxoplasmosis of the Brain					Prurigo			
Unexplained Chronic Diarrhea					Lymphoma			
Sever bacterial Pneumonia					Guillain-Barre Syndrome			
Extrapulmonary TB					HIV Encephalopathy			
Pulmonary TB					TB IRIS			
Herpes Zoster					Herpes Zoster IRIS			
PCP Pneumonia					PCP IRIS			
Cryptococcal Meningitis					Cryptococcal IRIS			
Kaposi's Sarcoma					Kaposi's Sarcoma IRIS			
HSV infection					HSV IRIS			
CMV Retinitis					CMV IRIS			
Malaria					Other -			
Hepatitis					Other -			

3. Has the patient experienced any of the following symptoms since last cohort visit? (specify duration in days)

Symptom	Yes	No	Duration		Symptom	Yes	No	Duration
Unexplained weight loss					Chest pain			
Recurrent fever					Chronic cough			

Night sweats					Shortness of breath			
Disturbed sleep pattern					Abdominal pain			
Loss of appetite					Diarrhea			
Painful nodules					Vomiting			
Skin swellings					Chronic headache			
Itching papular lesions					Neck stiffness/pain			
Skin rash (non-Prurigo)					Confusion			
Facial swellings					Forgetfulness			
Facial palsy or numbness					Behavioral changes			
Full blindness					Seizures			
Partial blindness					Focal paralysis			
Photophobia					Generalized paralysis			
Yellow eyes					Numbness/tingling in hands/feet			
Hearing loss					Coordination difficulties			
Oral swellings					Other -			
Mouth sores					Other -			
Pain on swallowing					Other -			

Section E. Clinical Exam				
System	**Not done**	**Done - normal**	**Done - with abnormal Clinical Condition(s)**	**Clinical Comments**
General	☐	☐	☐ enlarged lymph nodes ☐ supraclavicular ☐ axillae ☐ cervical ☐ epitrochlear ☐ submandibular ☐ inguinal ☐ edema ☐ facial ☐ limb ☐ pallor ☐ jaundice ☐ wasting ☐ diaphoresis ☐ calf tenderness ☐ finger clubbing ☐ other _____	
Skin	☐	☐	☐ herpes zoster ☐ Kaposi's Sarcoma ☐ seborrhea ☐ acne ☐ folliculitis ☐ psoriasis ☐ abscess ☐ cellulitis ☐ rash ☐ warts ☐ prurigo ☐ scabies ☐ molluscum contagiosum ☐ pigmentation changes ☐ other _____	
Eyes a) external	☐	☐	☐ conjunctivitis ☐ blindness ☐ discharge ☐ pain ☐ corneal abrasions ☐ ptosis ☐ limited movement ☐ visual field cuts ☐ other _____	
b) fundoscopic	☐	☐	☐ papilloedema ☐ nodules ☐ absent venous pulsations ☐ retinal hemorrhages ☐ cotton-wool spots ☐ retinal scarring ☐ macular edema ☐ epiretinal hemorrhages ☐ other _____	
Mouth	☐	☐	☐ oral candidiasis ☐ angular cheilitis ☐ KS lesions ☐ ulcers ☐ oral hairy leukoplakia ☐ poor dentition ☐ stomatitis ☐ other _____	

Ears/Sinuses	☐	☐	☐ otitis externa ☐ sinus tenderness ☐ otitis media ☐ loss of hearing ☐ discharge ☐ parotiditis ☐ mastoid tenderness ☐ other _____	
Cardiovascular	☐	☐	☐ cardiomegaly ☐ rub ☐ murmur ☐ abnormal pulse ☐ deep vein thrombosis ☐ cyanosis ☐ tachycardia ☐ carotid bruit ☐ hypotension ☐ precordial thrill ☐ increased jugular venous pressure ☐ other _____	
Pulmonary	☐	☐	☐ tachypnea ☐ ronchi ☐ crackles ☐ dullness ☐ tracheal deviation ☐ hyper-resonance ☐ accessory muscle use ☐ nasal flaring ☐ other _____	
GI	☐	☐	☐ enlarged liver ☐ enlarged spleen ☐ ascites ☐ rebound ☐ abdominal tenderness ☐ palpable masses ☐ guarding ☐ other _____	
Genitourinary a) GU	☐	☐	☐ genital warts ☐ syphilitic chancre ☐ herpes lesions ☐ other ulcerations ☐ pubic lice ☐ urethral discharge ☐ genital rash ☐ hernia ☐ other palpable mass ☐ hemorrhoids ☐ renal angle tenderness ☐ other _____	
b) Gyn ♀ only	☐	☐	☐ vaginal discharge ☐ vaginitis ☐ vaginal candidiasis ☐ abscess ☐ ulcers ☐ enlarged uterus ☐ palpable mass ☐ cervical tenderness ☐ generalized tenderness ☐ other _____	
Muscular-skeletal	☐	☐	☐ arthritis ☐ deformity ☐ joint swelling ☐ draining sinus ☐ muscle weakness ☐ lower extremity ulcerations ☐ other _____	
Neurologic a) central	☐	☐	☐ confusion ☐ memory loss ☐ flat affect ☐ meningismus ☐ cranial nerve palsies ☐ nuchal rigidity ☐ positive Kernig's ☐ aphasia ☐ other _____	
b) peripheral (motor & sensory)	☐	☐	☐ peripheral neuropathy ☐ difficulty walking ☐ paraesthesias ☐ rigidity ☐ hyper-reflexia ☐ muscle spasms ☐ paralysis ☐ other _____	
c) cerebellar	☐	☐	☐ ataxia ☐ nystagmus ☐ clumsiness ☐ tremor ☐ other_____	

Section F: ARV history (since last Cohort visit)	
1. Has the ARV-status changed since the last Cohort visit? ☐ Yes ☐ No	1-a: If Yes to # 1 continue with question 2-5. 1-b: If No to #1 continue with Section I.
2. Has the patient started ARV's since the last Cohort visit? ☐ Yes ☐ No	2-a. If Yes to #2: ARV-start-date ____/____/_____ DD/MM/YYYY Reason for starting (code): _____
3. If no to #1: Has the patient stopped ARV's since the last Cohort visit? ☐ Yes ☐ No	3-a. If Yes to #3 ARV-stop-date ____/____/_____ DD/MM/YYYY Reason for stopping (code) _____ Lead out? ☐ Yes ☐ No ☐ Not necessary
4. Has the patient switched ARV's since the last Cohort visit? ☐ Yes ☐ No	4-a. If Yes to #4 ARV-switch-date ____/____/_____ DD/MM/YYYY Reason for switching (code) _____
5. Has the patient interrupted ARV's since the last Cohort visit? ☐ Yes ☐ No	5-a. If Yes to #5 ARV-stop-date ____/____/_____ DD/MM/YYYY ARV-start-date ____/____/_____ DD/MM/YYYY Reason for interruption (stopping code): _____ Lead out? ☐ Yes ☐ No ☐ Not necessary

Section G: ARV status	
1. Is the patient on ARV's? ☐ Yes ☐ No	1-a If yes to #1 (on ARV's) code Regimen _____ Funding Source(s): _____ _____
2. If no to #1 (not on ARV's) Code reason _____	2.a Code Toxicities (today or since last cohort visit) related to current ARV-regimen _____ _____ _____ _____

Section H: ARV Status: Medication Adherence & Toxicities

1. Count the number of pills (when possible)

Name of tablet (only generic names)	Returned pills	Expected returned pills
I.		
II.		
III.		
IV.		

2. During the past 7 days, how many days did the patient miss taking all or part of your ARV medication(s)?

☐ 1 day ☐ 2 days ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐ No days

3. Indicate in the box below when the patient took the drugs

Put a "✓" if drugs taken and "x" if the patient missed a dose

Drug Name	**Yesterday**		**2 days ago**		**3 days ago**		**Last dose**	
							Date	Time (24hrs)
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.		
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.		
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.		
	a.m.	p.m.	a.m.	p.m.	a.m.	p.m.		

4. During the last 30 days, what percentage of time did the patient take the ARV medications?
(Circle appropriate number)

0 ----- 10 ----- 20 ----- 30 ----- 40 ----- 50 ----- 60 ----- 70 ----- 80 ----- 85 ----- 90 ----- 92 ----- 95 ----- 98 ----- 100

5. How often has the patient missed ARV medication in last month for the following reasons?

Reason	**Never**	**Rarely**	**Sometimes**	**Often**
Away from home				
Simply forgot				
Had too many pills to take				
Wanted to avoid side-effects				
Did not want people to notice you taking them				
Felt sick, depressed or overwhelmed				
Ran out of drugs				
Felt healthy				
Had a change in daily routine				

Section I: ARV Status: Medication Adherence & Toxicities (continued)

6. Did the patient miss any of the ARV medications last Saturday or Sunday?

☐ Yes ☐ No

7. When did the patient last miss taking the ARV medication?

☐ w/in the past week
☐ 1-2 weeks ago
☐ 2-4 weeks ago
☐ 1-3 months ago
☐ Never skip

8. Does someone help the patient remember to take her/his pills?

☐ Yes ☐ No

9. Does taking pills interfere with the patients' work or school?

☐ Yes ☐ No

Section J: ARV Plan	
1. Is the ARV-status going to change? ☐ Yes ☐ No	1-a. If Yes to # 1 continue with question 2-4. 1-b. If No to #1 continue with Section L.
2. Is the patient starting ARV's today? ☐ Yes ☐ No Regimen*:* _____ *Funding Source:* _____	2-a. If Yes to #2, code ARV-start-date: ____/____/_____ DD/MM/YYYY Reason for starting: _____
3. Is the patient stopping ARV's today? ☐ Yes ☐ No	3-a. If Yes to #3, code ARV-stop-date: ____/____/_____ DD/MM/YYYY Reason for stopping: _____
4. Is the patient switching ARV's today? ☐ Yes ☐ No Regimen*:* _____ *Funding Source:* _____	4-a. If Yes to #4, code ARV-switch-date: ____/____/_____ DD/MM/YYYY Reason for switching: _____

Section K: Concurrent conditions and Concomitant medication	
1. Cuncurrent medical conditions ☐ None ☐ Diabetes ☐ Hypertension ☐ Cancer (non HIV related Specfy _____ ☐ CVA(stroke) ☐ DVT ☐ Other cardiovascular condition Specfy _____ ☐ Asthma ☐ Epilepsy ☐Mental health illness Specfy _____ ☐ Disability → ☐Blind ☐Deaf ☐Missing limb ☐Polio ☐Other Specify_____ ☐ Other _____ _____ _____ _____ _____	
2. Hospitalization since the last study visit ☐None ☐HIV related Specify OI_____ ☐ Other medical condition ☐Surgical → ☐Abdominal ☐Thoracic ☐Gynecological ☐Other Specify_____	
3. Other current medications (new list) ☐ Multivitamins ☐ FeS04 ☐ Paracetamol ☐ Folic acid ☐ Corticosteroids ☐ NSAID ☐ Vitamin B complex ☐ Anti-Malarial ☐ Codeine ☐ Antibiotic mediactions _____ ☐ Other _____	☐ Antidiabethes → ◯ Insulin ◯ Metformine ◯ Glibenclamide ◯ Other specify _____ ☐ Anti Hypertension → ☐ Nifedipine ☐ Bendroflumethiazide ☐ Beta blockers ☐ Other specify _____ ☐ Chemotherapy ☐ Oral contraceptives → ◯ Lofeminal s ◯ Microgynom ◯ Other specify _____
4. In the last year have you taken herbal or traditional medications? ☐ Yes ☐ No	4-a. If yes to # 4, why? Increase strength, ☐ Yes ☐ No Increase appetite, ☐ Yes ☐ No Make more blood (hematinic) ☐ Yes ☐ No Increase immunity ☐ Yes ☐ No

	Spiritual Defense ☐ Yes ☐ No Other ☐ Yes ☐ No
5. Tobacco use ☐ Yes ☐ Present ☐ Past ☐ No	**6. Alcohol use** ☐ Yes ☐ Present ☐ Social ☐ Past ☐ Problem ☐ No

Section L. Laboratory tests		
CD4 count	☐ Yes	
Viral load	☐ Yes (week 96, 192, 288, 384 480)	☐ Not required (week 144, 240, 336, 432)
Hb	☐ Yes xx.x g/dL	
ALT	☐ Yes	
Urine analysis	☐ Yes ☐Normal ☐ Proteins	
Electrolytes	☐ Yes, urine analysis abnormal	☐ Not required (urine analysis normal)
CBC	☐ Yes, low Hb	☐ Not required (Hb normal)
Creatinine	☐ Yes, urine analysis abnormal	☐ Not required (urine analysis normal)
Pregnancy test	☐ Yes, LMP > 1 month ☐Neg ☐ Pos	☐ Not required
Cervical cancer screening *(female only)*	☐ Yes ☐Neg ☐ Pos	☐ Not required

Section M: Clinical Plan

Other Comments:

Medical Provider Name	Signature	Date

Return Appointment Date: _____	Return Appointment Date following schedule: _____