# **Baseline Medical History**

<ul><li>Purpose: Document medical his</li><li>When: Baseline visit.</li><li>By whom: Clinic coordinator an</li></ul>			ınd sy	mptoms.		
A. Clinic, patient, and visit ic	lentificatio	on		11. Highest formal education (check only one).	·	
				No formal education	(	1)
1. Clinic ID code:				Grade 8 or less	(	2)
<b>4 D</b>				Grade 9, 10, or 11	(	3)
2. Patient ID#:				Grade 12 or high school graduate	(	4)
<b>3.</b> Patient name code:				Some college	(	5)
3. I attent name code.			<del></del>	College graduate	(	6)
4. Date of visit:				One or more years post college	(	<sub>7</sub> )
		_=		12. Current employment status (check only one	e):	
day	mon	year		Disabled (unable to work)	(	1)
5. Visit ID code:	<u>B</u>	_ <u>L</u> _		Employed with income	(	2)
				Homemaker	(	3)
6. Sequence number of this	BH form	. 01 .6		Retired	(	4)
First form completed on a forms are needed, numb				Student	(	5)
quentially.		J		Unemployed	(	6)
				<b>13.</b> Insurance status (check all that apply)		
B. Personal data				a. Uninsured:	(	1)
7. Date of birth:				<b>b.</b> Medicare:	(	1)
<del>-</del>				c. Medicaid:	(	1)
day	mon	year		d. Veterans Administration:	(	1)
<b>8.</b> Age:				e. CHAMPUS:	(	1)
		years		<b>f.</b> Private health insurance:	(	1)
<b>9.</b> Gender:				14. True of agreeds health in suggest of the leave	1	\ -
Male		(	1)	<b>14.</b> Type of private health insurance ( <i>check onli</i>	ty oi	ne):
Female		(	2)	Closed panel health care organization membership (no outside subspecialty		
10. Race/ethnicity (check only	y one):			referrals permitted except in exceptional circumstances)	(	1)
White, non-Hispanic		(	1)	Insurer permits subspecialty referrals		
Black, non-Hispanic		(	2)	outside its organization with prior		
Hispanic		(	3)	approval	(	2)
Asian/Pacific Islander		(	4)	Patient may access subspecialty care	1	`
American Indian/Alaska	n Native	(	5)	without prior approval	(	3)
Other (specify):		(	6)	Neither private health insurance nor Medicare/Medicaid HMO	(	<sub>N</sub> )
other eth	ınic group					

15.	Height (without shoes):				
		( 1) inches	)	( centin	2) neters
16.	Weight (without shoes):				
	•_	( 1) pounds	) S	( kilog	<sub>2</sub> ) rams
17.	Blood pressure (after 5 minutes	restin	g)		
	a. Systolic:		mmH	 g	
	<b>b.</b> Diastolic:		mmH	g	

#### **D. HIV History**

**18.** HIV-exposure category (check all that apply)

F-57	
(	1)
(	1)
(	1)
(	1)
(	1)
(	1)
(	1)
	( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( ( (

For items 20., 24.-27., and 29.-34. refer to the **HIV-related Diagnosis Code List** in the SOCA General Handbook.

19. Date of HIV diagnosis:

**h.** No risk group reported:

	_
month	year

20.	Specify the disease or condition that
	resulted in diagnosis of AIDS (index
	diagnosis)

**a.** AIDS index diagnosis/condition:

	disease name/condition
b.	Diagnosis code:
c.	Date first diagnosed:
	month year

21. Nadir CD4+ T-cell count

a. Nadir CD4+ T-cell	count documented
in the medical reco	rds:

			cells/ µL	
<b>b.</b> Approx	ximate date of	nadir Cl	D4+	
T-cell	count:			

	_
month	year

For item 22, enter in the first space greater than ">" or less than "<" when exact HIV RNA determination is not obtained (eg < 000200) otherwise enter "0".

**23.** Patient ever diagnosed with CMV disease (ocular or systemic):

22. Highest HIV RNA level ever



Skip to item 28 after listing all CMV disease(s).

**24.** CMV disease (#1)

a. Location of Civi v discuse.	a.	Location	of C	CMV	disease:
--------------------------------	----	----------	------	-----	----------

<b>b.</b> Diagnosis	code:			
c. Date of dia	ignosis:			

day	mon	year

1)

- **25.** CMV disease (#2):
  - a. Location of CMV disease:
  - **b.** Diagnosis code:
  - **c.** Date of diagnosis:

=		=
day	mon	year

- **26.** CMV disease (#3)
  - a. Location of CMV disease:
  - **b.** Diagnosis code:
  - **c.** Date of diagnosis:

C		
day	mon	year

- 27. CMV disease (#4)
  - a. Location of CMV disease:
  - **b.** Diagnosis code:
  - **c.** Date of diagnosis:

_		_
day	mon	year

**28.** Has the patient been diagnosed with other HIV-related diseases (other than CMV disease):



Skip to item 35 after listing all HIV-related disease(s).

- **29.** Other HIV-related disease (#1)
  - a. Diagnosis:

	disease name
<b>b.</b> Diagnosis code:	

- **30.** Other HIV-related disease (#2)
  - a. Diagnosis:

	disease name
<b>b.</b> Diagnosis code:	

**31.** Other HIV-related disease (#3)

<b>a.</b> Diagnosis:		

b. I	Diagnosis code:		
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disease name

**32.** Other HIV-related disease (#4)

<b>a.</b> Diagnosis:		
	dicasca nama	

- **b.** Diagnosis code:
- **33.** Other HIV-related disease (#5)

<b>a.</b> Diagnosis:		
	disease name	

- **b.** Diagnosis code:
- **34.** Other HIV-related disease (#6)

<b>a.</b> Diagnosis:		
	disease name	

**b.** Diagnosis code:

### E. Other medical history

For each item 35. through 51., ask if the patient has ever been diagnosed with the following condition(s). Do not record disease already recorded under section D.

**35.** High blood pressure requiring medication:

Y	es .	N	o
(	1)	(	2

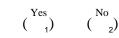
**36.** Patient diagnosed with hepatitis:

Type of hepatitis (check all that apply)

- **a.** Type A: ( 1)
- **b.** Type B: ( )
- **c.** Type C:
- **d.** Other (specify): (

specify	

**37.** Diabetes mellitus:



If Yes, date of diagnosis:

	_		
month		yea	ır

**38.** Hyperlipidemia:



If Yes, date of diagnosis:

	=
month	year

39. Renal disease:



**40.** Hematologic disease:

$$\binom{\text{Yes}}{1}$$
  $\binom{\text{No}}{2}$ 

**41.** Seizure disorder requiring medication (*specify*):

**42.** Other neurologic disease (*specify*):

$$\begin{pmatrix}
Yes \\
1
\end{pmatrix} \qquad \begin{pmatrix}
No \\
2
\end{pmatrix}$$

**43.** Tuberculosis:

3	Yes	N	Ю
(	1)	(	
	17		-

,)

**44.** Syphilis:

Yes		N	lo
(	1)	(	2)

**45.** Herpes zoster (specify location)

Yes (Yes	$\binom{\text{No}}{2}$
	. 2

location

**46.** Herpes simplex (specify location):

Yes		No	
(	1)	(	2)

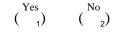
location

**47.** Other dermatologic disease (specify):

Y	es	N	lo
(	1)	(	2)

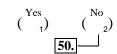
specify

**48.** Other diagnoses (*specify*):



specify

**49.** Stevens-Johnson syndrome:



a. Did conjunctival scarring ensue:

	Right	Left
Yes		( 2)
No	( 1)	$\begin{pmatrix} & & \\ & & 2 \end{pmatrix}$

50. Cardiovascular event

(if Yes, fill out CC form): Yes No 
$$\begin{pmatrix} 1 & 1 & 1 \\ 1 & 1 & 1 \end{pmatrix}$$

**51.** Cerebrovascular event

(if Yes, fill out CC form): Yes No 
$$\binom{1}{2}$$

### F. CMV syndromes questionnaire

Answers to the following may be used to decide whether further evaluation for CMV disease is warranted. Positive responses should be reviewed with the study physician, who will determine what (if any) diagnostic tests need to be performed.

#### Retinitis

**52.** Do you have any changes in the vision of either eye:

 $\begin{pmatrix} \text{Yes} \\ 1 \end{pmatrix} \qquad \begin{pmatrix} \text{No} \\ 2 \end{pmatrix}$ 

**53.** Is your vision blurred for both near and distant objects in either eye:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**54.** When you are looking at an object with only one eye, are there any blind spots:

Yes ( No ( 2)

**55.** Do you have floating spots in front of either eye:

Yes (No 1) (56.)

**a.** Are they worse in the daylight:

 $\begin{pmatrix}
Yes & No \\
\begin{pmatrix}
1
\end{pmatrix} & \begin{pmatrix}
No \\
2
\end{pmatrix}$ 

# CMV esophagitis

**56.** Do you have any pain, burning or other discomfort with swallowing in your throat (neck) or in your upper chest, beneath the breast bone:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

#### Gastroenteritis/colitis/proctitis

**57.** Do you have any abdominal pain:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

58. Do you have diarrhea:

(Yes 1) (No 2) **59.** 

a. Does it occur with abdominal pain:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**b.** Is the diarrhea a large or small amount *(check only one):* 

Large (more than 3 loose stools/day)

Small (less than or equal to 3 loose stools/day)

( 2)

**59.** Do you have any rectal pain:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**60.** Do you usually have to strain when you have a bowel movement:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**61.** Is there any blood and/or mucus with the stool:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

# Hepatitis/cholangitis

**62.** Do you have discomfort in the right upper part of your abdomen, including the area under your right ribs:

(Yes (No (No 2)

**a.** Is nausea or vomiting associated with this discomfort:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**63.** Do you have any fever:

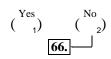
 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

#### **Pneumonitis**

**64.** Do you have shortness of breath:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**65.** Do you have a cough:



**a.** Is it productive:



## Radiculomyelitis

**66.** Do you have any decrease in leg or foot strength:

Yes No

**67.** Do you have any loss of bowel or bladder control:

 $\begin{pmatrix} \text{Yes} \\ 1 \end{pmatrix} \qquad \begin{pmatrix} \text{No} \\ 2 \end{pmatrix}$ 

**68.** Do you have any numbness or altered sensation in your arms, legs or torso:

 $\begin{pmatrix} \text{Yes} \\ 1 \end{pmatrix} \qquad \begin{pmatrix} \text{No} \\ 2 \end{pmatrix}$ 

### Meningoencephalitis

69. Have you had any seizures:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**70.** Do you feel unusually drowsy/weak/less alert than usual:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**71.** Have you had severe headache associated with neck stiffness and fever:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**72.** Do you have double vision:

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**73.** Have you had any abnormal bodily movements (*tremors*, *twitching*, *shaking*, *etc*):

 $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

## **Constitutional symptoms**

**74.** Do you have the following symptoms:

a. Generalized weakness:  $\binom{\text{Yes}}{1}$   $\binom{\text{No}}{2}$ 

**b.** Fatigue or lethargy:  $\binom{1}{2}$ 

**c.** Fever: ( <sub>1</sub>) ( <sub>2</sub>)

- **d.** Chills: ( 1) ( 2)
- **e.** Other (specify):  $\binom{1}{2}$

general symptom

### **Study Physician:**

**75.** Do any positive responses to questions 52-74 lead you to make a presumptive diagnosis or prompt you to evaluate further:

Yes	No
$\begin{pmatrix} 1 \end{pmatrix}$	( 2)
	76.

Specify diagnosis or testing indicated
--

**Instruction**: If any of the above current symptoms lead to a probable or confirmed diagnosis, record the diagnosis on the Followup Medical History form (FH), section C, at the next visit.

#### G. Cardiovascular/cerebrovascular risk factors

- 76. Cigarette smoking assessment
  - a. Do you smoke cigarettes now:



**b.** What is the average number of cigarettes you smoke each day:

cigarette(s)/day

### 77. Recreational drug use

**a.** When was the last time you used cocaine (crack, nose candy, freebase) (check only one):

Never	(	1)
less than 1 month	(	2)
Within 1-6 months	(	3)
Greater than 6 months	(	4)
Unknown	(	5)
Refused	(	6)

**b.** When was the last time you used methamphetamine (crystal meth) (*check only one*):

Never	(	1)
less than 1 month	(	2)
Within 1-6 months	(	3)
Greater than 6 months	(	4)
Unknown	(	5)
Refused	(	6)

**c.** When was the last time you used isobutyl nitrite/amyl nitrite (poppers) (*check only one*):

Never	(	1)
less than 1 month	(	2)
Within 1-6 months	(	3)
Greater than 6 months	(	4)
Unknown	(	5)
Refused	(	6)

7 of 8

## H. Karnofsky score

78. Patient's Karnofsky s		. 1	
to Karnofsky score; c	General Handbook r check only one):	eiai	ang
Normal; no complain disease - 100	nts; no evidence of	(	10)
Able to carry out not signs or symptoms o	•	(	09)
Normal activity with or symptoms of dise	_	(	(80
Cares for self; unable activity or to do activity	•	(	07)
Requires occasional able to care for most		(	06)
Requires considerable frequent medical car		(	05)
Disabled; requires spassistance - 40	pecial care and	(	04)
Severely disabled; he indicated although dimminent - 30	-	(	)
Very sick; hospitaliz	nation necessary; nent is necessary - 20	(	03)
Moribund; fatal proc rapidly - 10	-	(	01)

# I. Administrative information

**79.** Date form reviewed:

		day	mon	ye	ar
80.	Study ph	ysician ID:			
81.	Study ph	ysician signa	ature:		
82.	Clinic co	oordinator ID	:		
83.	Clinic co	ordinator sig	gnature:		