FORM 2: ADULT BASELINE CLINICAL EXAMINATION

(Form filled in by Clinician)

South African ID Number: | | | | | | | | | | | | | **Capturer:** | | | **Date of Visit:** d d / m m / y y y y

A. CURRENT/PREVIOUS ARV MEDICATION

1. Is the patient on any antiretroviral therapy at present or have they taken ARVs in the past? ○ Yes ○ No

If Yes, specify the type of ARV Exposure: *(If Yes, refer to Specialist Site - Section K)*

○ PMTCT ⟶ If known, what was taken: ○ Single Dose NVP ○ Double Dose NVP

○ PEP ⟶ If PEP specify: **Treatment Start Date:** d d / m m / y y y y **Treatment End Date:** d d / m m / y y y y

○ ARV Clinical Research Trials ⟶ What ARVs were taken and for how long:

○ ARVs for Treatment ⟶ What ARVs were taken and for how long:

Comments:

B. HOSPITALISATION AND MEDICATION

1. Has the patient been hospitalised within the last year? ○ Yes ○ No **1a. If so, how many times:**

If so, please give the reasons:

2. Has the patient been taking any medication other than ARVs? ○ Yes ○ No

Medication		Current Use	Comments
Cotrimoxazole (Bactrim)		○ Yes ○ No	
Fluconozole (Diflucan)		○ Yes ○ No	
Traditional Medicine		○ Yes ○ No	
Nutritional Supplements:	MVIs	○ Yes ○ No	
	Other	○ Yes ○ No	Specify:
Other 1 (specify):		○ Yes ○ No	
Other 2 (specify):		○ Yes ○ No	

3. Has the patient had a Nutritional Assessment? ○ Yes ○ No *(If No, refer to a Dietician - Section K)*

C. FAMILY PLANNING

Questions 2 to 5 are for **women** only

1. Is the patient using any means of contraception? ○ Yes ○ No

1a. If Yes, please specify which form of contraception is being used:

○ Condoms ○ Oral Contraceptives ○ Injectables ○ Tubal Ligation ○ Other *(Specify)* _____

2. Date of Last Menstrual Period: _____ *(If Unsure or LMP was more than 6wks ago then order Pregnancy Test - Section J)*

3. How many times has the patient been pregnant (Parity)? ☐☐

4. How many children has the patient given birth to (Gravidity)? ☐☐ *(Only include live births)*

5. When did she have her last PAP smear?

○ Less than a year ago ○ Between 1yr and 2yrs ○ Between 2yrs and 3yrs ○ More than 3yrs ○ Never Had

D. TUBERCULOSIS

1. Is the patient currently being treated for Tuberculosis?

○ No *(Specify)* →

Has the patient had Tuberculosis in the last year? ○ Yes ○ No

1a. If Yes, for how long was the patient on TB Treatment? _____

1b. Was the Treatment completed? ○ Yes ○ No

○ Yes *(Specify)* →

When was TB Treatment started: d d / m m / y y y y

Date Treatment was last taken: d d / m m / y y y y

2. How many people living in the patient's home have been screened for TB: ☐☐

3. How many living in the patient's home are currently on TB Treatment: ☐☐

E. SYMPTOM HISTORY

Indicate which of the following symptoms have been experienced by the patient in the last month:

Symptom/Sign	Yes	Symptom/Sign	Yes
Weight Loss	○	Abdominal Pains	○
Fatigue	○	Nausea/Vomiting	○
Thrush	○	Headache	○
Rash	○	Visual Changes	○
Cough	○	Dizziness	○
Night Sweats	○	Altered sensation in the extremities	○
Fever	○	Vaginal/Penile discharge, itching or burning	○
Shortness of Breath	○	Change in mood	○
Jaundice	○	Other:	○
Diarrhoea	○	Other:	○

F. PHYSICAL EXAMINATION

Height ☐.☐☐ **m**

Weight ☐☐☐.☐ **kgs**

Blood Pressure
Systolic ☐☐☐
Diastolic ☐☐☐

Temperature ☐☐.☐ **°C**

BMI $\frac{\text{Weight}}{(\text{Height})^2}$ ☐☐☐.☐☐

Examinations	Normal	Abnormal	Not Done	Comments/Descriptions
Hydration	○	○	○	
Jaundice	○ No	○ Yes	○	
Colour	○	○ Cyanosis ○ Pale	○	
Oedema	○	○	○	
Ear, Nose & Throat	○	○	○	
Head & Neck	○	○	○	
Cardiovascular	○	○	○	
Lungs	○	○	○	
Abdomen	○	○	○	
Lymph Nodes	○	○	○	
Skin	○	○	○	
Urogenital	○	○	○	
Musculoskeletal	○	○	○	
Neurological	○	○	○	
Other *(Specify):*	○	○	○	
Other *(Specify):*	○	○	○	

Comments:

G. WHO STAGE INDICATOR

1. Does the patient have any of these conditions:

WHO Stage 1	Yes	WHO Stage 4	Yes
Asymptomatic HIV Infection	○	Candidiasis *(Esophageal, Bronchi, Trachea or Lungs)*	○
Persistent Generalised Lymphadenopathy	○	Cryptococcosis, Extrapulmonary	○
WHO Stage 2		Cryptosporidiosis with Diarrhoea *(>1 month duration)*	○
Herpes Zoster *(within last 5 years)*	○	Cytomegalovirus Disease	○
Minor Mucocutaneous Manifestations	○	Herpes Simplex	○
Recurrent Upper Respiratory Tract Infections	○	HIV Encephalopathy	○
Weight Loss ≤ 10% of Body Weight	○	HIV Wasting Syndrome	○
WHO Stage 3		Kaposi's Sarcoma (KS)	○
Severe Bacterial Infections *(within last 5 years)*	○	Lymphoma	○
Oral Candidiasis (Thrush)	○	Atypical Mycobacteriosis, Disseminated	○
Unexplained Chronic Diarrhoea (>1 month)	○	Mycosis, Disseminated Endemic *(ie. Histoplasmosis, Coccidiodomycosis...)*	○
Unexplained Prolonged Fever *(Intermittent or constant > 1 month)*	○	Tuberculosis, Extrapulmonary	○
		Pneumocystis Pneumonia (PP)	○
Oral Hairy Leukoplakia	○	Progressive Multifocal Leukoencephalopathy (PML)	○
Tuberculosis, Pulmonary *(Within the last year)*	○	Salmonella Septicemia, Non-typhoid	○
Weight Loss > 10% of Body Weight	○	Toxoplasmosis, CNS	○

2. What is the patient's highest WHO Condition:

○ WHO Stage 1 ○ WHO Stage 2 ○ WHO Stage 3 ○ WHO Stage 4

Comments

H. WHO PERFORMANCE STAGE (Functional Status)

1. What is the patient's fuctional status:

1 ○ No Limitations (asymptomatic, normal activity)

2 ○ Ambulatory (able to bathe, eat, dress without assistance)

3 ○ In bed more than usual (but < 50% of normal daytime during the previous month)

4 ○ Bedridden (> 50% of normal daytime during previous month)

Comments

I. NON ARV MEDICATIONS

1. Are there any non-ARV medicines that need to be ordered/changed? ○ Yes ○ No

If Yes, please indicate which are to be ordered and which are to be changed:

Medication		Recommendation Start	Stop	Continue	Comments
Cotrimoxazole (Bactrim)		○	○	○	
Fluconozole (Diflucan)		○	○	○	
Traditional Medicine			○		
Nutritional Supplements:	MVIs	○	○	○	
	Other	○	○	○	Specify:
Other 1 (specify):		○	○	○	
Other 2 (specify):		○	○	○	

J. LAB INVESTIGATIONS (To Order)

- ○ Viral Load
- ○ FBC
- ○ LFTs
- ○ Chemistries
- ○ Pregnancy Test
- ○ PAP Smear
- ○ Hepatitis B Rapid Test
- ○ TB Sputum (AFB)
- ○ Chest X-Ray
- ○ Other *(Specify):*

K. REFERRALS

Reason for Referral

- ○ Social Work
- ○ Counselling
- ○ TB Clinic
- ○ Inpatient/Hospital
- ○ Antenatal
- ○ Dietician
- ○ Specialist/Nodal Site *(Specify name of Site and Reason)*
- ○ Other *(Specify name of referral and Reason)*

Comments:

Next Appointment Date: d d / m m / y y y y **Time:** h h : m m *(24 hrs - eg. 13:30)*