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CLINICAL INTERFOLLOW-UP - EXTENSION I
MEDICAL REVIEW AND EXAMINATION
(If patient has died, complete only at AVD)
Clinic Code
Patient ID
Letter Code (A-Z)
Annual Visit
A V
Visit Date

MEDICAL EXAMINATION

1. Vital signs:
   A. Pulse (beats per minute) PULSE ___
   B. Blood pressure (mm Hg)
      Systolic SBP ___
      Diastolic DBP ___
   C. Respiratory rate, breaths per minute RESPRATE ___
2. Weight WEIGHT ___.___ kg
3. Lymphadenopathy:

	Yes	No	N/R
A. Cervical LYMP_CER	(1)	(2)	(3)
B. Axillary LYMP_ANC	(1)	(2)	(3)
C. Groin LYMP_GRN	(1)	(2)	(3)
D. Other LYMP_OTH	(1)	(2)	(3)

4. Lung fields clear LUNGCLR (1) (2) (3)
5. Heart exam:

	Yes	No	N/R
A. Sinus rhythm SINUS	(1)	(2)	(3)
B. S3 gallop S3GALLOP	(1)	(2)	(3)
C. Murmurs MURMURS	(1)	(2)	(3)

   If YES, answer: MURMTYPE Flow (1) Pathologic (2)
6. Abdominal exam:
   A. Liver span LIVER ___ cm
   B. Tenderness

	Yes	No	N/R
1. Right Upper Quadrant	(1)	(2)	(3) LIV_RUQ
2. Right Lower Quadrant	(1)	(2)	(3) LIV_RLQ
3. Left Upper Quadrant	(1)	(2)	(3) LIV_LUQ
4. Left Lower Quadrant	(1)	(2)	(3) LIV_LLQ

MEDICAL REVIEW

7. Since the last MSH medical review:

	Yes	No	N/R
A. Chronic transfusion program	(1)	(2)	(3) CHR_TO
B. Immunosuppression	(1)	(2)	(3) IMMUNO
C. Serious infection	(1)	(2)	(3) INFECT
D. Chest syndrome	(1)	(2)	(3) CHST_HX
E. Stroke	(1)	(2)	(3) STRK_HX
F. Congestive heart failure	(1)	(2)	(3) CHF_HX
G. Chronic pulmonary failure	(1)	(2)	(3) CPF_HX
H. Cholecystectomy	(1)	(2)	(3) CHOL_HX
I. Avascular necrosis of the hip or hip joint replacement	(1)	(2)	(3) AVAS_HX
J. Skin/leg ulcers	(1)	(2)	(3) SKINULCR
K. Skin rash/eruption	(1)	(2)	(3) SKIN_HX
L. Other skin abnormality	(1)	(2)	(3) OTH_HX

	Yes	No	N/A
NAIL_HX M. Nail discoloration/abnormality	(1)	(2)	(3)
HRLOS_HX N. Hair loss	(1)	(2)	(3)
GIDIS_HX O. Serious GI disturbance	(1)	(2)	(3)
BLEED_HX P. Bleeding tendency	(1)	(2)	(3)
HEMAT_HX Q. Hematuria	(1)	(2)	(3)
PRIAP_HX R. Priapism	(1)	(2)	(3)
IMPOT_HX S. Impotence	(1)	(2)	(3)
SCLERAL T. Scleral icterus	(1)	(2)	(3)
APLAS_HX U. Aplastic anemia	(1)	(2)	(3)

	Pos.	Neg.	N/R
HIV_TEST V. HIV test	(1)*	(2)	(3)

8. Has the patient ever had cancer or leukemia? CALEU_HX (1)* (2) (3)
9. Does the patient have a family history of cancer or leukemia? FAMCA_HX (1)* (2) (3)

** If YES to any of these, please attach documentation.*

10. Has patient ever been a regular tobacco user? TOBACCO (1) (2) (3)

If YES, answer items A. - E.

	Yes	No	N/R
A. Pipes PIPES	(1)	(2)	(3)
B. Cigars CIGARS	(1)	(2)	(3)
C. Cigarettes CIGRTS	(1)	(2)	(3)
D. Smokeless tobacco CHEWTOB	(1)	(2)	(3)

E. How old when began to use? TOB_AGE ___ Years
F. Pack-years (cigarettes) PACK_YRS ___

A. Current use of alcoholic beverages: ALC_CUR
None (1) Light (2) Moderate (3) Heavy (4)

B. Highest level of use of alcoholic beverages ever: ALC_HIGH
None (1) Light (2) Moderate (3) Heavy (4)

C. Total years of alcohol use (any level): ALC_YRS
Never (1) <1 (2) 1-5 (3) 6-10 (4) 11-20 (5) >20 (6)

A V

	Yes	No	N/R
12. Does the patient have a history of exposure to agents that are associated with high risk of cancer, mutagenicity or teratogenicity? ...CAEXPRSK	(1)*	(2)	(3)
13. Has patient ever been exposed to levels of radiation other than background or diagnostic? RADEXP	(1)*	(2)	(3)
14. Does the patient have a history of hepatitis? ..HEPAT-HX	(1)*	(2)	(3)

** If YES to any of these, please attach documentation.*

15. Is this patient enrolled in any treatment studies? STUDIES (1) (2) (3)

If yes, randomized clinical trial (1) (2) RANDOMIZ

Non-randomized treatment trial (1) (2) NONRANDOMIZ

16. **SINCE THE LAST ANNUAL VISIT:**

A. HOW MANY TIMES HAS PATIENT OR PARTNER BECOME PREGNANT? (0) (1) (2) (3) (4)

B. IS PATIENT OR PARTNER CURRENTLY PREGNANT? CUR_PREG (1) Yes (2) No

If any there have been any new pregnancies or patient is currently pregnant, complete one line per pregnancy in items 16.-19. Otherwise, skip to item 20.

A. Month/Year Pregnancy Started (e.g., APR/1998)	B. Documentation of Diagnosis? Attached Previously Submitted	C. Status or outcome of pregnancy
17. ____/_____ P1_MOYR	(1) (2) P1_DOC	(1) Live birth (Complete Form 51) (2) Other resolution of pregnancy P1_OUTC (3) In progress
18. ____/_____ P2-MOYR	(1) (2) P2_DOC	(1) Live birth (Complete Form 51) (2) Other resolution of pregnancy P2_OUTC (3) In progress
19. ____/_____ P3_MOYR	(1) (2) P3_DOC	(1) Live birth (Complete Form 51) (2) Other resolution of pregnancy P3_OUTC (3) In progress
20. ____/_____ P4_MOYR	(1) (2) P4_DOC	(1) Live birth (Complete Form 51) (2) Other resolution of pregnancy P4_OUTC (3) In progress

21. Checked for completeness and accuracy
Assist. Signature:

[illegible]

Retain a copy of this form for your files. Send the original to the Medical Coordinating Center, Maryland Medical Research Institute, 600 Wyndhurst Avenue, Baltimore, Maryland 21210, or by FAX transmission to 410/435-4232. Thank you.

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