INITIAL HISTORY AND PHYSICAL

Patient ID ☐☐☐ - ☐☐☐ - ☐☐☐☐☐ - ☐
District / Facility / Serial no.

Date ☐☐ / ☐☐ / ☐☐ (Day / Month / Year)

Facility ID (if different) ☐☐☐☐☐

Clinic code ☐☐

Patient Last Name _____ Patient First Name _____

BACKGROUND

Sex: ◯ Female ◯ Male

NRC number: ☐☐☐☐☐☐ / ☐☐ / ☐

Date of birth: ☐☐ / ☐☐ / ☐☐☐☐ (Day / Month / Year)

Date of birth is an estimate: ◯ Yes ◯ No

Age ☐☐

Patient has disclosed status:
◯ Yes
◯ No

Status disclosed to:
☐ Spouse/partner
☐ Family member
☐ Friend
☐ Child
☐ Other_____

Partner status:
◯ Deceased
◯ Alive
◯ No partner

Partner was tested:
◯ Yes ◯ No
◯ Don't know

Partner result:
◯ Positive
◯ Negative
◯ Unknown

Patient is referred from:
◯ Outpatient (OPD)
◯ TB corner/ chest clinic
◯ Inpatient
◯ MCH / PMTCT
◯ Youth-friendly corner
◯ General VCT
◯ Outside clinic
◯ Project_____
◯ Other_____

PAST MEDICAL HISTORY

Has patient ever been diagnosed with the following diseases? If yes write year under YY column.

Liver disease	◯ Yes	YY	◯ No	STI (other than HIV)	◯ Yes	YY	◯ No
Diabetes	◯ Yes		◯ No	Heart disease	◯ Yes		◯ No
Kidney disease	◯ Yes		◯ No	Hypertension	◯ Yes		◯ No
Lung disease	◯ Yes		◯ No	Psychiatric illness	◯ Yes		◯ No

Specify STI: _____

☐ Smoking: # cigs/day_____# yrs_____

☐ Alcohol: # drinks/wk_____# yrs_____

☐ Other_____

If yes, describe: _____

TB HISTORY

Patient currently on TB medication
◯ Yes ◯ No

Date of current diagnosis: ☐☐ / ☐☐ / ☐☐ (Day / Month / Year)

Current TB drugs:
◯ RHZE
◯ SRHZE
◯ EH
◯ RHE

Type of current TB:
◯ Pulmonary:
- ◯ Smear positive
- ◯ Smear negative
- ◯ Smear unknown

◯ Extrapulmonary

PAST TB EPISODES
(mo/yr treatment started)

Month ☐☐ Year ☐☐
◯ Pulmonary ◯ Extrapulmonary

Month ☐☐ Year ☐☐
◯ Pulmonary ◯ Extrapulmonary

FAMILY PLANNING

Current patient/partner family planning:
☐ None
☐ Condoms
☐ Oral contraceptive pills
☐ Injectable/implanted hormones
☐ Other_____

OBSTETRIC HISTORY

Is patient currently pregnant? ◯ Yes ◯ No
Is patient breastfeeding? ◯ Yes ◯ No
How many times has patient been pregnant? _____
How many live births has the patient had? _____
How many children are now living? _____
Was patient tested for HIV in previous pregnancies? ◯ Yes ◯ No
If medication was given for PMTCT was it ingested? ◯ Yes ◯ No

Expected date of delivery: ☐☐ / ☐☐ / ☐☐ (Day / Month / Year)

PMTCT drugs (tick all taken):
☐ NVP
☐ AZT
☐ Other: _____

ARV DRUG HISTORY

Tick all ever taken. If not currently taking give reason stopped.

REASONS FOR STOP	
A) Pregnancy	H) Anaemia
B) Treatment failure	I) Neuropathy
C) Poor adherence	J) Rash
D) TB medication	K) Pancreatitis
E) Patient decision	L) Lactic acidosis
F) Drug interaction	M) Other side effect
G) Drug unavailable	N) Physician decision

NRTIs	Current?	Reason stopped
☐ Zidovudine (AZT)	☐	___
☐ Stavudine (D4T)	☐	___
☐ Lamivudine (3TC)	☐	___
☐ Abacavir (ABC)	☐	___
☐ Tenofovir (TDF)	☐	___
☐ Didanosine (ddI)	☐	___
☐ Emtricitabine (FTC)	☐	___

NNRTIs	Current?	Reason stopped
☐ Nevirapine (NVP)	☐	___
☐ Efavirenz (EFV)	☐	___
PIs		
☐ Lopinavir/ritonavir (LPV/r)	☐	___
☐ Indinavir (IDV)	☐	___
☐ Nelfinavir (NFV)	☐	___

OTHER CURRENT MEDICATIONS

☐ Septrin
☐ Fluconazole
☐ Traditional medicines
☐ Anti-malarials
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____
☐ Other_____

Drug allergies:

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PRESENTING COMPLAINT

☐ Numbness/pain/burning in legs/feet

Tick at left if PATIENT mentions any complaints. Note duration, recurrence below.

☐ Routine visit ☐ Acute diarrhoea ☐ Visual problems
☐ No complaint ☐ Chronic diarrhoea ☐ Headache
☐ Weight loss ☐ Sores in mouth ☐ Rash
☐ Fever ☐ Pain/diff swallowing ☐ Swellings/lymph nodes
☐ Night sweats ☐ Cough ☐ Other
☐ Vomiting ☐ Shortness of breath ☐ Lab results_____ mm/yy___/___

REVIEW OF SYSTEMS

Within the <u>past</u> <u>month</u>, has the patient experienced any of the following symptoms:

CONSTITUTIONAL

Fatigue (tired)	◯ Yes ◯ No
*Fever	◯ Yes ◯ No
*Night sweats	◯ Yes ◯ No
Appetite loss	◯ Yes ◯ No
*Weight loss	◯ Yes ◯ No

GASTROINTESTINAL

Acute diarrhoea	◯ Yes ◯ No
Chronic diarrhoea	◯ Yes ◯ No
Nausea and/or vomiting	◯ Yes ◯ No
Oral lesions	◯ Yes ◯ No
Pain/difficulty swallowing	◯ Yes ◯ No
Abdominal pain	◯ Yes ◯ No

CARDIO-RESPIRATORY

*Productive cough	◯ Yes ◯ No
*Non-productive cough	◯ Yes ◯ No
*Hemoptysis	◯ Yes ◯ No
*Difficulty breathing/SOB	◯ Yes ◯ No
Dizziness	◯ Yes ◯ No
Palpitations	◯ Yes ◯ No
Swelling of legs	◯ Yes ◯ No

NEUROLOGICAL

Daily headache	◯ Yes ◯ No
Memory problems	◯ Yes ◯ No
Visual problems	◯ Yes ◯ No
Confusion	◯ Yes ◯ No
Numbness/pain/burning in legs/feet	◯ Yes ◯ No
Weakness in limbs	◯ Yes ◯ No
Seizures	◯ Yes ◯ No

GENITAL-URINARY

Genital ulcers	◯ Yes ◯ No
Discharge (urethral/vaginal)	◯ Yes ◯ No
Abnormal bleeding	◯ Yes ◯ No
Dysuria	◯ Yes ◯ No
Hematuria	◯ Yes ◯ No

OTHER

Rash	◯ Yes ◯ No
Joint pain/swelling	◯ Yes ◯ No

Last recorded weight: _____ Date weight taken (mo/yr): _____

** If symptom present, screen for TB using TB Diagnostic Worksheet (where in use)*

If yes, describe:

PHYSICAL EXAM

Height (cm) ☐☐☐ Weight (kg) ☐☐☐.☐ ☐ Height/weight not taken because patient cannot stand BMI ☐☐

BP ☐☐☐/☐☐☐ Temp. C ☐☐.☐ Heart rate/min ☐☐☐ Resp rate ☐☐

	Normal	Abnormal	*Describe any abnormal findings below*
Skin	◯	◯	
Eyes	◯	◯	
Ears, nose	◯	◯	
Oral	◯	◯	
Lymph nodes	◯	◯	
Heart	◯	◯	
Lungs	◯	◯	
Abdomen	◯	◯	
Urogenital	◯	◯	
Musculoskeletal	◯	◯	
Neurological	◯	◯	

General: ☐ Pallor ☐ Jaundice ☐ Edema

Clerk initial _____ Staff ID _____ Staff signature _____

WHO STAGING

STAGE 1
- ☐ Asymptomatic HIV infection
- ☐ Persistent gen. lymphadenopathy

STAGE 2
- ☐ Weight loss < 10% body weight
- ☐ Recurrent URIs
- ☐ Herpes zoster
- ☐ Sores/cracks around lips
- ☐ Recurrent mouth ulcers
- ☐ Itching rash
- ☐ Itchy, scaly skin condition
- ☐ Fungal nail infections of fingers

STAGE 3
- ☐ Weight loss > 10% body weight
- ☐ Unexpl. chronic diarrhoea (> 1 mo)
- ☐ Unexpl. persistent fever (> 1 mo)
- ☐ Oral candidiasis
- ☐ Oral hairy leukoplakia
- ☐ Pulmonary TB
- ☐ Severe bacterial infections
- ☐ Severe painful oral ulcers
- ☐ Unexplained anaemia (<8 g/dl)

WHO Stage today
◯ 1 ◯ 2 ◯ 3 ◯ 4

STAGE 4
- ☐ HIV Wasting Syndrome (> 10% wt loss and > 1 mo diarrhea and > 1 mo fever)
- ☐ Pneumocystis pneumonia
- ☐ Recurrent severe or radiological bacterial peumonia
- ☐ Chronic herpes simplex (> 1 mo)
- ☐ Oesophageal candidiasis
- ☐ Extrapulmonary TB
- ☐ Kaposi's sarcoma
- ☐ CNS toxoplasmosis
- ☐ HIV encephalopathy
- ☐ Cryptococcal meningitis
- ☐ Other stage 4:_____

Functional status: ◯ Healthy, able to work ◯ Sick, able to work ◯ Sick, unable to work ◯ Bedridden

ASSESSMENT

Opportunistic infections should be ticked above under WHO Staging. Other conditions noted:

- ☐ Malaria
- ☐ STI, specify:_____
- ☐ *TB suspect *use TB Diagnostic Worksheet*
- ☐ Anaemia
- ☐ Hypertension
- ☐ Diabetes
- ☐ Acute diarrhoea
- ☐ Chronic diarrhoea
- ☐ Fever
- ☐ Respiratory Tract Infection
- ☐ Urinary Tract infection
- ☐ Other_____

PLAN

◯ Assess for ART Eligibility ◯ Continue ART ◯ Modify ART ◯ Stop ART

Use the ARV Eligibility Form to initiate / continue / modify treatment.

Do at next visit:

PRESCRIPTIONS

Pregnant? ◯ Yes ◯ No

- ☐ Septrin prophylaxis 960mg od x ____days ◯ Start ◯ Cont. ◯ Stop
- ☐ Septrin treatment_____mg_____X_____days
- ☐ Fluconazole maint. 200mg od x ____days ◯ Start ◯ Cont. ◯ Stop
- ☐ Fluconazole treat._____mg_____X_____days
- ☐ Other_____:_____mg_____X_____days
- ☐ Other_____:_____mg_____X_____days
- ☐ Fansidar_____
- ☐ Coartem_____
- ☐ Other_____
- ☐ Multivit 1 tab od x1mo
- ☐ Iron 200mg tds x1mo
- ☐ Folate 5mg od x1mo

TB DRUGS
- ◯ RHZE _____tabs od x_____mo
- ☐ S _____mg im od x_____mo
- ◯ EH _____tabs od x_____mo
- ◯ RHE _____tabs od x_____mo

INVESTIGATIONS
- ☐ None
- ☐ CD4 count
- ☐ Hemoglobin/hematocrit
- ☐ Full blood count
- ☐ ALT/AST
- ☐ Creatinine
- ☐ *Sputum AFB
- ☐ Chest X-ray
- ☐ Pregnancy
- ☐ RPR
- ☐ TLC
- ☐ Amylase/lipase
- ☐ Viral load
- ☐ Other:_____

REFERRALS
- ☐ None
- ☐ Family planning
- ☐ Nutritional support
- ☐ Inpatient care (this facility)
- ☐ Inpatient care:_____
- ☐ *TB treatment/DOT program
- ☐ Adherence counseling
- ☐ Treatment preparation
- ☐ Psychosocial support
- ☐ Community health worker
- ☐ Consented to HBC
- ☐ Other:_____

**If suspect TB, complete TB Diagnostic Worksheet (where in use)*

Next clinical appointment should be in:
◯ 1 wk ◯ 2 wks ◯ 3 wks ◯ 1 mo ◯ 3 mos ◯ 6 mos ◯ Other:_____

Date of next visit: ☐☐ / ☐☐ / ☐☐
Day / Month / Year

Clerk initial _____ Staff ID _____ Staff signature _____