

INITIAL HISTORY AND PHYSICAL

Date / /
Day Month Year

Patient ID - - -
District Facility Serial no.

Facility ID (if different)
 Clinic code

Patient Last Name _____

Patient First Name _____

Clinic code

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 No YY

STI (other than HIV) Yes No YY

Specify STI: _____

Diabetes Yes No

Heart disease Yes No

Smoking: # cigs/day _____ # yrs _____

Kidney disease Yes No

Hypertension Yes No

Alcohol: # drinks/wk _____ # yrs _____

Lung disease Yes No

Psychiatric illness Yes No

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 H) Anaemia

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

NRTIs

Zidovudine (AZT) Stavudine (D4T) Lamivudine (3TC) Abacavir (ABC) Tenofovir (TDF) Didanosine (ddl) Emtricitabine (FTC)

Current? Reason stopped

NNRTIs

Nevirapine (NVP) Efavirenz (EFV) Lopinavir/ritonavir (LPV/r) Indinavir (IDV) Nelfinavir (NFV)

Current? Reason stopped

PIs

OTHER CURRENT MEDICATIONS

Septrin
 Fluconazole
 Traditional medicines
 Anti-malarials
 Other _____
 Other _____
 Other _____
 Other _____
 Other _____

Drug allergies:

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 past month, 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

General: Pallor Jaundice Edema

- Skin Normal Abnormal _____
- Eyes Normal Abnormal _____
- Ears, nose Normal Abnormal _____
- Oral Normal Abnormal _____
- Lymph nodes Normal Abnormal _____
- Heart Normal Abnormal _____
- Lungs Normal Abnormal _____
- Abdomen Normal Abnormal _____
- Urogenital Normal Abnormal _____
- Musculoskeletal Normal Abnormal _____
- Neurological Normal Abnormal _____

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 pneumonia
- 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:

- | | | | |
|--|---------------------------------------|--|--|
| <input type="checkbox"/> Malaria | <input type="checkbox"/> Anaemia | <input type="checkbox"/> Acute diarrhoea | <input type="checkbox"/> Respiratory Tract Infection |
| <input type="checkbox"/> STI, specify: _____ | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Chronic diarrhoea | <input type="checkbox"/> Urinary Tract infection |
| <input type="checkbox"/> *TB suspect use TB Diagnostic Worksheet | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Fever | <input type="checkbox"/> 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:

<p>PRESCRIPTIONS Pregnant? <input type="radio"/> Yes <input type="radio"/> No</p> <p><input type="checkbox"/> Septrin prophylaxis 960mg od x ___ days <input type="radio"/> Start <input type="radio"/> Cont. <input type="radio"/> Stop</p> <p><input type="checkbox"/> Septrin treatment _____ mg _____ X _____ days</p> <p><input type="checkbox"/> Fluconazole maint. 200mg od x ___ days <input type="radio"/> Start <input type="radio"/> Cont. <input type="radio"/> Stop</p> <p><input type="checkbox"/> Fluconazole treat. _____ mg _____ X _____ days</p> <p><input type="checkbox"/> Other _____ : _____ mg _____ X _____ days</p> <p><input type="checkbox"/> Other _____ : _____ mg _____ X _____ days</p> <p><input type="checkbox"/> Fansidar _____</p> <p><input type="checkbox"/> Coartem _____</p> <p><input type="checkbox"/> Other _____</p> <p><input type="checkbox"/> Multivit 1 tab od x1mo</p> <p><input type="checkbox"/> Iron 200mg tds x1mo</p> <p><input type="checkbox"/> Folate 5mg od x1mo</p> <div style="border: 1px solid black; padding: 5px; margin-top: 5px;"> <p>TB DRUGS</p> <p><input type="radio"/> RHZE _____ tabs od x _____ mo</p> <p><input type="checkbox"/> S _____ mg im od x _____ mo</p> <p><input type="radio"/> EH _____ tabs od x _____ mo</p> <p><input type="radio"/> RHE _____ tabs od x _____ mo</p> </div>	<p>INVESTIGATIONS</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> CD4 count</p> <p><input type="checkbox"/> Hemoglobin/hematocrit</p> <p><input type="checkbox"/> Full blood count</p> <p><input type="checkbox"/> ALT/AST</p> <p><input type="checkbox"/> Creatinine</p> <p><input type="checkbox"/> *Sputum AFB</p> <p><input type="checkbox"/> Chest X-ray</p> <p><input type="checkbox"/> Pregnancy</p> <p><input type="checkbox"/> RPR</p> <p><input type="checkbox"/> TLC</p> <p><input type="checkbox"/> Amylase/lipase</p> <p><input type="checkbox"/> Viral load</p> <p><input type="checkbox"/> Other: _____</p>	<p>REFERRALS</p> <p><input type="checkbox"/> None</p> <p><input type="checkbox"/> Family planning</p> <p><input type="checkbox"/> Nutritional support</p> <p><input type="checkbox"/> Inpatient care (this facility)</p> <p><input type="checkbox"/> Inpatient care: _____</p> <p><input type="checkbox"/> *TB treatment/DOT program</p> <p><input type="checkbox"/> Adherence counseling</p> <p><input type="checkbox"/> Treatment preparation</p> <p><input type="checkbox"/> Psychosocial support</p> <p><input type="checkbox"/> Community health worker</p> <p><input type="checkbox"/> Consented to HBC</p> <p><input type="checkbox"/> Other: _____</p>
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**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