



Adult Clinical Evaluation

Initial Visit
 Follow-up Visit

Facility Name: _____

1. Visit Date (dd/mm/yyyy) _____ / _____ /20_____

2. Name _____

_____ Other Names

3. ID _____
State Facility No. Serial Enrollment No.

4. Hospital No. _____

5. Presenting complaint:

6. Symptoms in the past month (check all that apply).
 Fever Nausea and/or vomiting Difficulty of breathing
 Night sweats Diarrhoea Memory problems
 Fatigue Thrush Depression
 Weakness Pain – Abdominal Other 1 (specify) _____
 Weight loss Rash _____
 Weight gain Cough Other 2 (specify) _____
 Headache Pain – Muscle _____
 New visual problems Pain – Legs/feet Other 3 (specify) _____
 Poor appetite Numbness or tingling in legs and/or feet _____

FOR INITIAL VISIT ONLY

7. Family history / additional comments: _____

8. Past medical problems: _____

9. Previous ARV exposure
Treatment Months Specify
 OPMTCT _____
 Treatment _____

FOR FOLLOW UP VISIT ONLY

10. Illnesses since last visit:

11. Drug allergies: _____

12. Hospitalization: _____

13. Is patient taking:
a. Herbal supplement Y N b. Traditional medicines Y N

FOR FEMALE PATIENT ONLY
14a. Last menstrual period _____ / _____ / _____
14b. Currently pregnant Y N Uncertain
14c. Gestational age _____ weeks
14d. Expected date of delivery _____ / _____ / _____

15. Latest CD4 (if available) _____ Counts/mL
Date _____ / _____ / _____

16. Latest VL (if available) _____ Counts/mL
Date _____ / _____ / _____ Lab records seen

17. Current medications (probe and specify) None
 ART _____
 TMP/SMX _____
 Anti-TB meds _____
 Other (specify) _____
 Other (specify) _____

18. Presumed ARV side effects:
Past (if this is initial visit) or Current (if this is follow-up visit).
 N/A Peripheral neuropathy Pancreatitis
 None Rash Fat accumulation or loss
 Significant nausea/vomit Jaundiced Hyperglycemia
 Headache Stevens Johnson syndrome Kidney problems
 Diarrhoea Itching Hepatitis
 Pain abdomen or muscle Anaemia Lactic acidosis
 Insomnia/bad dreams Weakness/fatigue Other (specify) _____
 Confusion/dizzy _____

19. Physical Exam

Temp _____ °C	BP _____ / _____ mm/Hg			
Pulse _____	Wt _____ kg	Ht _____ m		
	Normal	Abnormal	Not Done	Comments
General appearance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Head and Neck	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
ENT	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Abdomen	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Anorectal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Genitourinary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lymph nodes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Extremities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Musculoskeletal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Neurological	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Other (specify in comments)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

20. Functional status Working Ambulatory Bedridden

21. WHO staging criteria (History of any of the following) – Past/current if Initial Visit; If Follow-Up Visit, only check new diagnoses since last visit and re-stage if necessary.

- Asymptomatic
- Persistent generalized lymphadenopathy
- Performance scale: 1 asymptomatic, normal activity

Stage 1

- Weight loss <10% of body weight
- Minor mucocutaneous manifestations
- Herpes zoster (within last 5 years)
- Recurrent Upper respiratory tract infections
- Performance scale: 2 symptomatic, normal activity

Stage 2

- Weight loss >10% of body weight
- Unexplained chronic diarrhea (>1 mth)
- Unexplained prolonged fever
- Oral candidiasis
- Oral hairy leukoplakia
- TB, Pulmonary (within previous year)
- Severe bacterial infections
- Performance scale: 3 bedridden <50% of day in last month

Stage 3

- HIV wasting syndrome
- PCP
- Toxoplasmosis, CNS
- Cryptosporidiosis with diarrhea (>1 mth)
- Cryptococcosis, Extrapulmonary
- Cytomegalovirus disease
- Herpes simplex (mucocutaneous >1 mth)
- Progressive multifocal leukoencephalopathy
- Mycosis, disseminated
- Esophageal candidiasis
- Atypical mycobacteriosis, disseminated
- Salmonella Septicemia, Non-typhoid
- TB, extrapulmonary
- Lymphoma
- Kaposi's sarcoma
- HIV encephalopathy
- Performance scale: 4 bedridden >50% of the day in last month

Stage 4

22. Only complete at Initial Visit or if change to more advanced WHO stage at Follow Up Visit.

23. TB Status:
- No signs or symptoms suggesting TB
 - Sputum sample sent - date, sputum results and date received
 - Currently on INH prophylaxis, dose, adherence
 - Currently on TB treatment → Duration _____
 - Suspected TB, referred for evaluation (include referral date)
 - Prior history of treated TB

24. Assessment and Plan

25. List all medication being started, stopped or continued:

Medication	Recommendation			Reasons for Discontinuation*	Dose and Comments
	Start	Stop	Continue		
Zidovudine (AZT)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Lamivudine (3TC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Stavudine (D4T)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Didanosine (DDI)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Abacavir (ABC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Tenofovir (TDF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Emtricitabine (FTC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Truvada (TDF+FTC)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nevirapine (NVP)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Efavirenz (EFV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Nelfinavir (NFV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Kaletra (LPV/r)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ritonavir (RTV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Saquinavir (SQV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Isoniazid (INH)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Rifampicin (RIF)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
TMP/SMX (Cotrimoxazole)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Ethambutol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Pyrazinamide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
Other (specify):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		

* Reason for discontinuation:
 1 = Side effect / Toxicity / Drug interaction 3 = Patient non-adherence 5 = PMTCT prophylaxis complete
 2 = Disruption in drug supply / Stock out 4 = Treatment failure 6 = Patient refused
 7 = Other, specify _____

26. What referrals will be made for the patient

- None
- In-patient care / Hospitalization
- Mental health services
- Home-based care
- Other referral (specify) _____
- Family planning services
- TB treatment / DOT program
- Psychosocial counseling
- Clean water
- _____
- Nutritional support
- Adherence counseling
- Social support services
- Insecticide treated nets
- _____

27. When is the patient's next appointment? 1 week 2 weeks 4 weeks 2 months 3 months → _____ / _____ /20

Clinician Signature _____

Print Name _____