

Site Number: _____ Screening ID: _____ - ____

Participant Letters: _____

Complete this form for all regularly scheduled Follow-up Visits.

A. VISIT INFORMATION

1. Visit Date:

____ / ____ / ____
DAY MONTH YEAR

2. For which visit is this form being completed? (check one)

- | | | | | |
|-----------------------------------|--------------------------------------|--------------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> 3 Week 1 | <input type="checkbox"/> 11 Month 3 | <input type="checkbox"/> 26 Month 15 | <input type="checkbox"/> 30 Month 30 | <input type="checkbox"/> 99 Other |
| <input type="checkbox"/> 4 Week 2 | <input type="checkbox"/> 16 Month 6 | <input type="checkbox"/> 27 Month 18 | <input type="checkbox"/> 31 Month 36 | |
| <input type="checkbox"/> 5 Week 3 | <input type="checkbox"/> 17 Month 9 | <input type="checkbox"/> 28 Month 21 | <input type="checkbox"/> 32 Month 42 | |
| <input type="checkbox"/> 6 Week 5 | <input type="checkbox"/> 18 Month 12 | <input type="checkbox"/> 29 Month 24 | <input type="checkbox"/> 33 Month 48 | |

If OTHER, a. Specify: _____

B. GENERAL PHYSICAL EXAMINATION

1. Collect the following physical assessments:

Note: Have the participant rest for 5 minutes before doing these assessments.

- a. Temperature: _____ °C or _____ °F
- b. Seated arm blood pressure: _____ mmHg / _____ mmHg
Systolic Diastolic
- c. Seated heart rate: _____ Beats/minute
- d. Seated respiratory rate: _____ Breaths/minute
- e. Weight: _____ kg or _____ lbs
- f. Height: _____ cm or _____ in

2. Record whether the following systems are reported as normal or abnormal by the participant and normal or abnormal upon examination: (if not done, write “*”)

Review of Systems	1) Participant Reported		2) Normal on Exam?		If Either is ABNORMAL, a) Explain:
	Normal?				
a. HEENT	Y	N	Y	N	_____
b. Neck	Y	N	Y	N	_____
c. Thyroid	Y	N	Y	N	_____
d. Lungs	Y	N	Y	N	_____
e. Chest/Breasts	Y	N	Y	N	_____
f. Heart/Circulatory	Y	N	Y	N	_____
g. Abdomen	Y	N	Y	N	_____
h. Musculoskeletal	Y	N	Y	N	_____
i. Neurologic	Y	N	Y	N	_____
j. Genitourinary/Testes	Y	N	Y	N	_____
k. Skin/Nails	Y	N	Y	N	_____
l. Lymph nodes	Y	N	Y	N	_____
m. Other	Y	N	Y	N	_____

If OTHER, 3) Specify: _____

Initials (first, middle, last) of person completing this form: _____
F M L

Date form completed: ____ / ____ / ____
DAY MONTH YEAR

On all questions write “?” if the desired information is currently unavailable, but is being checked and will be known in future updates. Write “*” if the desired information is permanently unavailable (i.e. will not be known in any future updates).

