

PIVENS

BC - Blood Collection for DNA

Purpose: Document the collection of whole blood for shipment to NIDDK Genetics Repository at Rutgers University for DNA extraction. Complete this form only if the patient signed the consent for genetic research.

When: Visit s2, rz, and as needed during followup. You can complete only one BC form prior to randomization. If a redraw of blood is necessary prior to randomization, revise the existing BC form to reflect the most recent blood draw for DNA banking. If redraw is necessary on the day of randomization, complete the BC form with visit code rz but hold the form for keying until after the patient has been randomized (you will not be able to key the form until after the patient has been randomized). If redraw is done after randomization or if the initial draw for DNA is done after randomization (eg, a patient who previously refused consent changes their mind to allow DNA banking), use the visit code for the followup visit whose time window is open. If redraw is done so soon after randomization that a followup visit window is not open, use visit code n.

By whom: Clinical Coordinator and laboratory personnel responsible for collection of whole blood.

Instructions: (1) Fill two 10 mL EDTA vacutainer tubes with whole blood. (2) Pack and ship the whole blood in the EDTA tubes to the NIDDK Genetics Repository at Rutgers University on the same day blood is collected. Ship at ambient room temperature. Ship whole blood in the specimen shippers supplied by the NIDDK Genetics Repository.

A. Center, patient and visit identification

1. Center ID: _____
2. Patient ID: _____
3. Patient code: _____
4. Date of visit:
 _____ day _____ mon _____ year
5. Visit code: _____
6. Form & revision: b c 1
7. Study: PIVENS 2

B. Check on consent

8. Did the patient consent to blood draw for DNA extraction:

Yes (1) No (* 2)


* You cannot proceed until you get consent.

9. Did the patient previously provide blood for DNA banking in the NAFLD Database:

Yes (1) No (2)
 15. _____

C. Specimen for Genetics Repository

Attach ID labels to two 10mL EDTA tubes and fill each with whole blood; invert each tube gently 6 times to mix blood with additives; keep tubes at room temperature until the same day shipment to the NIDDK Genetics Repository.

10. Was blood collected for the NIDDK Genetics Repository:

Yes (1)
 11. _____
 No, (specify): (2)

 specify
 15. _____

11. Date and time of blood draw

a. Date: _____ day _____ mon _____ year

b. Time: _____ : _____ (1) (2)
 hour minute am pm

12. Number of 10 mL EDTA tubes: _____

13. Form copy of tube labels:

PIVENS Form BC
 Pt: ccc- 9999, xyz
 Gender
 Age, yrs.: XX

14. Phlebotomist:

 print name

D. Administrative information

15. Clinical Coordinator PIN: ____ ____ ____

16. Clinical Coordinator signature:

17. Date form reviewed:
____ - ____ - ____
day mon year

PIVENS

BG - Baseline History

Purpose: To collect baseline history information about the patient.

When: Visit s1.

Administered by: Clinical Coordinator, reviewed by Study Physician.

Respondent: Patient.

Instructions: Collect information by interview or chart review. If ☐ is checked for an item, use caution. If the physician agrees with the diagnosis, the patient is ineligible for PIVENS. If ☒ is checked for an item, the patient is ineligible and cannot enroll in PIVENS. The form should not be keyed to the data system, but the form should be retained; set aside with forms for other patients who started screening, but were found to be ineligible.

A. Center, visit, and patient identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date (*date this form is initiated*):

_____ day _____ mon _____ year

5. Visit code: s 1 _____

6. Form & revision: b g 1

7. Study: PIVENS 2

B. Family history

8. Do any of the patient's first degree relatives (parent, brother, sister, child) have liver disease:

(Yes) (No)
(1) (2)

10. _____

9. If yes, characterize the liver disease(s) (*check all that apply*)

a. Alcohol related liver disease: (1)

b. Viral hepatitis: (1)

c. Alpha-1 antitrypsin deficiency: (1)

d. Wilson's disease: (1)

e. Glycogen storage disease: (1)

f. Iron overload: (1)

g. Fatty liver disease (*NAFLD, NASH*): (1)

h. Type of liver disease unknown: (1)

10. Do any of the patient's first degree relatives (parent, brother, sister, child) have cirrhosis:

(Yes) (No)
(1) (2)

12. _____

11. If yes, is the cause of the cirrhosis unknown (cryptogenic):

(Yes) (No)
(1) (2)

12. Do any of the patient's first degree relatives (parent, brother, sister, child) have diabetes (Type 1 or Type 2):

Yes (1)

No (2)

Don't know (3)

13. Do any of the patient's first degree relatives (parent, brother, sister, child) have obesity:

Yes (1)

No (2)

Don't know (3)

14. Do any of the patient's first degree relatives (parent, brother, sister, child) have atrophy of body fat:

Yes (1)

No (2)

Don't know (3)

15. Do any of the patient's first degree relatives (parent, brother, sister, child) have a problem with cholesterol or blood fat:

Yes (1)

No (2)

Don't know (3)

C. NASH history

16. Date patient was first diagnosed with nonalcoholic steatohepatitis (NASH):

____ day ____ mon ____ year

17. What prompted the evaluation for NASH (check all that apply)

- a. Symptoms for liver disease: (1)
 b. Result of being evaluated for another illness: (1)
 c. During a routine or insurance physical examination: (1)
 d. Blood donation: (1)
 e. Other (specify): (1)

specify

18. What procedures/tests supported this first diagnosis (check all that apply)

- a. Liver biopsy: (1)
 b. Imaging studies (Ultrasound, CT, MRI): (1)
 c. Elevated aminotransferases: (1)
 d. Other (specify): (1)

specify

D. Weight history

19. What was the patient's birthweight:

____ lbs ____ oz

20. Review flashcard 9. Which (picture) best describes your weight pattern over the past 5 years (check only one):

- Up and down, up and down (1)
 Up gradually (2)
 Up sharply (gained a lot in a brief interval) (3)
 Down gradually (4)
 Down sharply (lost a lot in a brief interval) (5)
 No or minimal change (6)

21. What is the patient's current weight (ask the patient for his/her weight):

____ lbs

22. What is the most the patient has ever weighed:

____ lbs

23. At what age did the patient weigh the most:

____ age in years

24. What is the least the patient has ever weighed since age 18:

____ lbs

25. At what age did the patient weigh the least since age 18:

____ age in years

26. Does the patient weigh more than he/she did one year ago:

(Yes) (No)
(1) (2)

28. _____

27. How much more does the patient weigh now compared to one year ago:

____ lbs

28. Does the patient weigh less than he/she did one year ago:

(Yes) (No)
(1) (2)

30. _____

29. How much less does the patient weigh now compared to one year ago:

____ lbs

30. Did the patient try to lose or gain weight:

(Yes) (No)
(1) (2)

32. _____

31. Which did the patient try to do (check only one):

Gain weight (1)
 Lose weight (2)

E. Tobacco cigarette smoking history*(interview with patient; not by chart review)***32.** Have you ever smoked tobacco cigarettes:

Never (1)

37. _____

In the past but not anymore (2)

Currently smokes cigarettes (3)

33. Did you smoke cigarettes regularly (“No” means less than 20 packs of cigarettes in a lifetime or less than 1 cigarette a day for one year):

(Yes (1) No (2))

37. _____**34.** How old were you when you first started regular cigarette smoking: _____ years**35.** How old were you when you (last) stopped smoking cigarettes (code as “n” if the patient didn’t stop smoking):

_____ years

36. On the average of the entire time that you smoked cigarettes, how many cigarettes did you smoke per day:

_____ cigarettes/day

F. Menstrual history**37.** Is the patient female:

(Yes (1) No (2))

42. _____**38.** What was the patient’s age at menarche:

_____ age in years

39. Characterize the menstrual history in the past 5 years (check only one):

Regular periods (1)

Irregular periods (2)

Rare periods (3)

No periods (4)

40. Is patient post-menopausal:

(Yes (1) No (2))

42. _____**41.** What was the patient’s age at menopause:

_____ age in years

G. Medical history (means Caution; condition is exclusionary if study physician agrees with diagnosis)

42. Has the patient ever been diagnosed with or treated for any of the following (check all that apply; source of information can be interview and/or chart review)

- a.** Diabetes type 1:  ()
- b.** Diabetes type 2:  ()
- c.** Gestational diabetes (diabetes of pregnancy): ()
- d.** Hepatitis B:  ()
- e.** Hepatitis C:  ()
- f.** Autoimmune hepatitis:  ()
- g.** Autoimmune cholestatic liver disorder (PBC or PSC):  ()
- h.** Wilson's disease:  ()
- i.** Alpha-1-antitrypsin (A1AT) deficiency:  ()
- j.** Iron overload:  ()
- k.** Drug induced liver disease:  ()
- l.** Gilbert's syndrome: ()
- m.** Esophageal or gastric varices on endoscopy:  ()
- n.** Bleeding from varices:  ()
- o.** Other gastrointestinal bleeding: ()
- p.** Biliary diversion:  ()
- q.** Ascites:  ()

- r.** Edema: ()
- s.** Hepatic encephalopathy:  ()
- t.** Portal hypertension:  ()
- u.** Hepatorenal syndrome:  ()
- v.** Hepatopulmonary syndrome:  ()
- w.** Short bowel syndrome:  ()
- x.** Hemophilia (bleeding disorder):  ()
- y.** Systemic autoimmune disorder such as rheumatoid arthritis or systemic lupus: ()
- z.** Endocrine disease (hormonal abnormality): ()
- aa.** Hepatocellular carcinoma:  ()
- ab.** Other malignancy (cancer):  ()
- ac.** Human immunodeficiency virus (HIV):  ()
- ad.** Peripheral neuropathy: ()
- ae.** Seizure disorder or epilepsy: ()
- af.** Drug allergies: ()
- ag.** Hypothyroidism: ()
- ah.** Hypertension: ()
- ai.** Cerebrovascular disease: ()
- aj.** Dysbetalipoproteinemia:  ()
- ak.** Hyperlipidemia (high cholesterol, high triglycerides): ()
- al.** Pancreatitis: ()
- am.** Cholelithiasis:  ()
- an.** Coronary artery disease:  ()

- ao.** Congestive heart failure:  (1)
- ap.** Elevated uric acid such as gout: (1)
- aq.** Kidney disease: (1)
- ar.** Polycystic ovary syndrome: (1)
- as.** Sleep apnea (*not breathing during sleep*): (1)
- at.** Dermatologic disorders: (1)
- au.** Myopathy: (1)
- av.** Myositis: (1)
- aw.** Major depression: (1)
- ax.** Schizophrenia: (1)
- ay.** Bipolar disorder: (1)
- az.** Obsessive compulsive disorder: (1)
- ba.** Severe anxiety or personality disorder: (1)
- bb.** Substance abuse:  (1)
- bc.** None of the above: (1)
- 43.** Has the patient ever had bariatric surgery for any of the following (*check all that apply*)
- a.** Stapling or banding of the stomach:  (1)
- b.** Jejunioileal (*or other intestinal*) bypass:  (1)
- c.** Biliopancreatic diversion:  (1)
- d.** Other GI or bariatric surgery (*specify*): (1)
- _____
- e.** None of the above: (1)

44. Organ, limb, or bone marrow transplant

- a.**
- Has the patient ever received a liver transplant:

(Yes) (No)
 (1) (2)


- b.**
- Has the patient ever received any other organ, limb, or bone marrow transplant:

(Yes) (No)
 (1) (2)

- 45.**
- Has the patient received total parenteral nutrition (TPN) in the past 12 months:

(Yes) (No)
 (1) (2)


- 46.**
- Is the patient currently undergoing evaluation for bariatric surgery:

(Yes) (No)
 (1) (2)


H. Drugs historically associated with NAFLD

- 47.**
- Has the patient used any of the following in the past 2 years

- a.** Amiodarone (Cordarone, Pacerone): (1)
- b.** Demeclocycline (Declomycin): (1)
- c.** Divalproex (Depakote): (1)
- d.** Doxycycline (Monodox): (1)
- e.** Methotrexate (Rheumatrex): (1)
- f.** Minocycline (Dynacin, Minocin): (1)
- g.** Oxytetracycline (Terramycin): (1)
- h.** Tetracycline (Achromycin): (1)
- i.** Valproate sodium (Depacon): (1)
- j.** Valproic acid (Depakene): (1)
- k.** Other known hepatotoxin (*specify*): (1)

l. None of the above: (1)

- 48.**
- Were any of the items on 47a-k checked:

(Yes) (No)
 (* 1) (2)


**Caution: Use of any of these drugs for more than 2 consecutive weeks in the past 2 years is exclusionary.*

49. Has the patient taken any systemic corticosteroids in the past 2 years (*check all that apply*):

- a.** Betamethasone sodium (Celestone): (1)
- b.** Cortisol: (1)
- c.** Cortisone: (1)
- d.** Dexamethasone (Decadron): (1)
- e.** Hydrocortisone (Hydrocortone): (1)
- f.** Methylprednisolone (Solu-Medrol): (1)
- g.** Prednisolone (Prelone): (1)
- h.** Prednisone: (1)
- i.** Triamcinolone (Acetocot, Amcort, Aristocort, Kenacort): (1)
- j.** Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. None of the above: (1)

50. Were any of the items 49a-k checked:

Yes (* 1) No (2)



**Caution: Use of systemic glucocorticoids for more than 2 consecutive weeks in the past 2 years is exclusionary.*

51. Has the patient taken any estrogen, progestin, anabolic steroids, hormone replacement therapy, or selective estrogen receptor modulators in the past 2 years (*check all that apply*):

- a.** Boldenone undecylenate (Equipose): (1)
- b.** Conjugated estrogen (Premarin/Prempro): (1)
- c.** Diethylstilbestrol and methyltestosterone (Tylosterone): (1)
- d.** Esterified estrogen (Estratab, Menest): (1)
- e.** Estradiol (Estrace): (1)
- f.** Ethinyl estradiol (Estinyl): (1)
- g.** Fluoxymesterone (Android-F, Halotestin): (1)
- h.** Levonorgestrel (Norplant): (1)
- i.** Medroxyprogesterone (Cycrin, Provera): (1)
- j.** Megestrol (Megace): (1)
- k.** Methandrostenolone (Dianabol): (1)
- l.** Methyltestosterone (Android): (1)
- m.** Nandrolone (Deca-Durabolin, Durabolin, Hybolin Decanoate, Kabolin): (1)
- n.** Norethindrone (Micronor): (1)
- o.** Norgestrel (Ovrette): (1)
- p.** Oral contraceptives (Alesse, Demulen, Desogen, Estrostep, Genora, Intercon, Levlen, Levlite, Levora, Loestrin, Lo-Ovral, Necon, Nelova, Nordette, Norethin, Norinyl, Ortho Cyclen, Ortho-Novum, Ortho Tri-Cyclen, Ovral, Tri-Levlen, Triphasil, Trivora, Zovia): (1)
- q.** Oxandrolone (Oxandrin): (1)
- r.** Oxymetholone (Anadrol): (1)
- s.** Progesterone (Prometrium): (1)
- t.** Raloxifene (Evista): (1)
- u.** Stanzolol (Winstrol): (1)
- v.** Tamoxifen (Nolvadex): (1)
- w.** Testosterone (Depo-Testosterone): (1)

x. Other, (specify): (1)

y. Other, (specify): (1)

z. None of the above: (1)

52. Were any of the items 51a-y checked:

Yes (* 1) No (2)


**Caution: Use of anabolic steroids, tamoxifen, or estrogens at doses greater than those used for hormone replacement for more than 2 consecutive weeks in the past 2 years is exclusionary.*

I. Use of antidiabetic drugs

53. Does the patient have a known intolerance for thiazolidinediones (rosiglitazone, pioglitazone):

Yes (1) No (2)


54. Has the patient used any antidiabetic medications in the past 12 months (check all that apply):

a. Acarbose (Precose): (1)

b. Acetohexamide (Dymelor): (1)

c. Chlorpropamide (Diabinese): (1)

d. Glimepiride (Amaryl): (1)

e. Glipizide (Glucotrol, Glucotrol XL): (1)

f. Glyburide (Micronase, DiaBeta, Glynase): (1)

g. Insulin: (1)

h. Metformin (Glucophage, Glucophage XR): (1)

i. Miglitol (Glycet): (1)

j. Nateglinide (Starlix): (1)

k. Pioglitazone (Actos): (1)

l. Repaglinide (Prandin): (1)

m. Rosiglitazone (Avandia): (1)

n. Tolazamide (Tolinase): (1)

o. Tolbutamide (Orinase): (1)

p. Other, (specify): (1)

q. None of the above: (1)

55. Were any of the items 54a-p checked:

Yes (* 1) No (2)


**Caution: Use of antidiabetic drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

J. Use of antiNASH drugs and vitamins

56. Has the patient taken any of these antiNASH drugs in the past 12 months (*check all that apply*)

- a. Betaine (Cystadone): (1)
- b. Choline + methionine + betaine + adenosine + pyridoxine (Epocler): (1)
- c. Metformin: (1)
- d. Ursodeoxycholic acid (UDCA, Actigall, URSO, Ursodiol): (1)
- e. S-adenylmethionine (SAM-e): (1)
- f. Milk thistle: (1)
- g. Probiotics (*any form*): (1)
- h. Gemfibrozil (Gen-Fibro, Lopid): (1)
- i. None of the above: (1)

57. Were any of the items in 56a-h checked:

(Yes) (No)
 (* 1) (2)
 C

**Caution: Use of antiNASH drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

58. Has the patient taken any antitumor necrosis factor (anti-TNF) therapies in the past 12 months (*check all that apply*):

- a. Etanercept (Enbrel): (1)
- b. Infliximab (Remicade): (1)
- c. Other, (*specify*): (1)

d. None of the above: (1)

59. Were any of the items 58a-c checked:

(Yes) (No)
 (* 1) (2)
 C

**Caution: Use of anti-TNF therapies in the 3 months prior to liver biopsy or randomization is exclusionary.*

60. Has the patient taken a multivitamin regularly in the past 12 months:

(Yes) (No)
 (1) (2)

61. Has the patient taken any vitamin E (either as a supplement or in a multivitamin) in the past 12 months):

(Yes) (No)
 (1) (2)

63.

62. Was/Is the dose of vitamin E greater than 100 IU/day:

(Yes) (No)
 (* 1) (2)
 C

**Caution: Use of vitamin E at more than 100 IU/day in the 3 months prior to biopsy or randomization is exclusionary.*

63. Is the patient willing to refrain from taking vitamin E in amounts greater than 100 IU/day during PIVENS:

(Yes) (No)
 (1) (* 2)
 Eng

**Patient may not take vitamin E supplements at doses greater than 100 IU/day during PIVENS.*

64. Does the patient have a known intolerance to vitamin E:

(Yes) (No)
 (1) (2)
 Eng

65. What other vitamins (other than multivitamins and vitamin E) has the patient taken in the past 12 months (*check all that apply*):

- a. Vitamin B (any type): (1)
- b. Vitamin C: (1)
- c. Vitamin D: (1)
- d. Other, (*specify*): (1)
- e. None of the above: (1)

K. Use of statins, fibrates, and antiobesity drugs

66. Has the patient taken any antihyperlipidemic medications in the past 12 months (*check all that apply*):

- a.** Atorvastatin (Lipitor): (1)
- b.** Colestipol hydrochloride (Colestid): (1)
- c.** Clofibrate (Abitrate, Atromid-S, Claripex, Novofibrate): (1)
- d.** Fenofibrate (Tricor): (1)
- e.** Fluvastatin sodium (Lescol): (1)
- f.** Lovastatin (Mevacor): (1)
- g.** Nicotinic acid (Niaspan): (1)
- h.** Pravastatin sodium (Pravachol): (1)
- i.** Rosuvastatin (Crestor): (1)
- j.** Simvastatin (Zocor): (1)
- k.** Other, (*specify*): (1)

l. None of the above: (1)

67. Were any of the items 66a-k checked:

Yes (* 1) No (2)



**Caution: Use of non-stable doses of statins or fibrates in the 3 months prior to liver biopsy or randomization is exclusionary.*

68. Has the patient taken any antiobesity medications in the past 12 months (*check all that apply*):

- a.** Dexfenfluramine hydrochloride (Redux): (1)
- b.** Fenfluramine hydrochloride (Pondimin): (1)
- c.** Methamphetamine hydrochloride (Desoxyn, Gradumet): (1)
- d.** Orlistat (Xenical): (1)
- e.** Phendimetrazine tartrate (Adipost, Bontril): (1)
- f.** Phentermine hydrochloride (Adipex, Fastin, Ionamin, Teramine): (1)
- g.** Sibutramine hydrochloride monohydrate (Meridia): (1)
- h.** Other, (*specify*): (1)

i. Other, (*specify*): (1)

j. None of the above: (1)

69. Were any of the items 68a-i checked:

Yes (* 1) No (2)



**Caution: Use of antiobesity medications in the 3 months prior to randomization is exclusionary.*

L. Use of other medications and supplements

70. Has the patient taken any cardiovascular or antihypertensive medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Amlodipine besylate (Norvasc): (☐)
- b.** Atenolol (Tenormin): (☐)
- c.** Benazepril (Lotensin): (☐)
- d.** Captopril (Capoten): (☐)
- e.** Clonidine (Catapres): (☐)
- f.** Digoxin (Lanoxin): (☐)
- g.** Diltiazem (Cardizem): (☐)
- h.** Doxazosin (Cardura): (☐)
- i.** Enalapril (Vasotec): (☐)
- j.** Felodipine (Plendil): (☐)
- k.** Furosemide (Lasix): (☐)
- l.** Hydrochlorothiazide (Esidrix, HydroDIURIL): (☐)
- m.** Hydrochlorothiazide + triamterene (Dyazide): (☐)
- n.** Lisinopril (Prinivil, Zestril): (☐)
- o.** Losartan potassium (Cozaar): (☐)
- p.** Losartan potassium with hydrochlorothiazide (Hyzaar): (☐)
- q.** Metoprolol (Lopressor): (☐)
- r.** Nifedipine (Adalat, Procardia): (☐)
- s.** Perhexiline maleate: (☐)
- t.** Propranolol (Inderal): (☐)
- u.** Quinapril (Accupril): (☐)
- v.** Terazosin (Hytrin): (☐)
- w.** Timolol maleate (Blocadren): (☐)
- x.** Valsartan (Diovan): (☐)
- y.** Verapamil (Calan): (☐)
- z.** Other, (*specify*): (☐)

aa. Other, (*specify*): (☐)

ab. None of the above: (☐)

71. Has the patient taken any pain relieving, non-steroidal anti-inflammatory, or aspirin containing medications in the past 12 months (*check all that apply*):

- a.** Acetaminophen (Tylenol): (☐)
- b.** Aspirin - 325 mg: (☐)
- c.** Aspirin - 81 mg: (☐)
- d.** Celecoxib (Celebrex): (☐)
- e.** Ibuprofen (Advil, Motrin): (☐)
- f.** Indomethacin (Indocin): (☐)
- g.** Naproxen (Aleve, Naprosyn): (☐)
- h.** Rofecoxib (Vioxx): (☐)
- i.** Valdecoxib (Bextra): (☐)
- j.** Other, (*specify*): (☐)

k. Other, (*specify*): (☐)

l. Other, (*specify*): (☐)

m. None of the above: (☐)

72. Has the patient taken any strong opiates containing acetaminophen medication in the past 12 months (*check all that apply*):

- a.** Darvocet: (☐)
- b.** Esgic - Plus: (☐)
- c.** Fioricet: (☐)
- d.** Lorcet: (☐)
- e.** Lortab: (☐)
- f.** Norco: (☐)
- g.** Percocet: (☐)
- h.** Talacen: (☐)
- i.** Tylenol #3: (☐)
- j.** Tylenol #4: (☐)
- k.** Tylox: (☐)
- l.** Vicodin: (☐)
- m.** Wygesic: (☐)
- n.** Other, (*specify*): (☐)

o. None of the above: (☐)

73. Has the patient taken any histamine H2 receptor antagonists or other gastrointestinal medications in the past 12 months (*check all that apply*):

- a.** Cimetidine (Tagamet): (1)
- b.** Esomeprazole magnesium (Nexium): (1)
- c.** Famotidine (Pepcid): (1)
- d.** Lansoprazole (Prevacid): (1)
- e.** Nizatidine (Axid): (1)
- f.** Omeprazole (Prilosec): (1)
- g.** Ranitidine (Zantac): (1)
- h.** Ranitidine bismuth citrate (Tritec): (1)
- i.** Antacids, (*specify*): (1)

- j.** Other, (*specify*): (1)

- k.** Other, (*specify*): (1)

- l.** None of the above: (1)

74. Has the patient taken any anticoagulant or antiplatelet medications in the past 12 months (*check all that apply*):

- a.** Clopidogrel (Plavix): (1)
- b.** Dipyridamole: (1)
- c.** Heparin: (1)
- d.** Ticlopidine (Ticlid): (1)
- e.** Warfarin (Coumadin): (1)
- f.** Other, (*specify*): (1)

- g.** Other, (*specify*): (1)

- h.** None of the above: (1)

75. Has the patient taken any allergy or asthma medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Albuterol: (1)
- b.** Beclomethasone dipropionate (Beclovent, Vanceril): (1)
- c.** Budesonide (Pulmicort, Rhinocort): (1)
- d.** Fluticasone propionate (Flonase, Flovent): (1)
- e.** Loratadine (Claritin): (1)
- f.** Mometasone furoate (Nasonex): (1)
- g.** Triamcinolone acetonide (Azmecort, Nasacort): (1)
- h.** Other, (*specify*): (1)

- i.** Other, (*specify*): (1)

- j.** None of the above: (1)

76. Has the patient taken any supplements in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Alpha-lipoic acid: (☐)
- b.** Beta-carotene: (☐)
- c.** Calcium (any form): (☐)
- d.** Carnitine (any form): (☐)
- e.** Chondroitin (any form): (☐)
- f.** Cod liver oil: (☐)
- g.** Coenzyme Q: (☐)
- h.** Dichloroacetate: (☐)
- i.** Echinacea: (☐)
- j.** Fish oil (any form): (☐)
- k.** Flax seed oil: (☐)
- l.** Garlic: (☐)
- m.** Ginkgo biloba: (☐)
- n.** Glucosamine (any form): (☐)
- o.** Lecithin: (☐)
- p.** Magnesium: (☐)
- q.** N-acetyl-cysteine: (☐)
- r.** Potassium (any form): (☐)
- s.** Saw palmetto: (☐)
- t.** Selenium: (☐)
- u.** St. John's Wort: (☐)
- v.** Taurine: (☐)
- w.** Zinc picolinate: (☐)
- x.** Other, (*specify*): (☐)

y. Other, (*specify*): (☐)

z. None of the above: (☐)

77. Has patient taken any of the following medications in the past 12 months (*check all that apply*):

- a.** Isotretinoin (Accutane): (☐)
- b.** Levothyroxine (Levoxyl, Synthroid): (☐)
- c.** Liothyronine (Cytomel): (☐)
- d.** Penicillamine (Cuprimine, Depen): (☐)
- e.** Trientine hydrochloride (Syprine): (☐)
- f.** Other, (*specify*): (☐)

- g.** Other, (*specify*): (☐)

- h.** Other, (*specify*): (☐)

- i.** Other, (*specify*): (☐)

- j.** Other, (*specify*): (☐)

- k.** None of the above: (☐)

78. Has the patient taken any alcohol abuse, inhaled or injection drugs (dependence or withdrawal) medications in the past 12 months (*check all that apply*):

- a. Chlordiazepoxide (Librium): (1)
 b. Clorazepate dipotassium (Tranxene): (1)
 c. Diazepam (Valium): (1)
 d. Disulfiram (Antabuse): (1)
 e. Hydroxyzine pamoate (Vistaril): (1)
 f. Naltrexone hydrochloride (Revia): (1)
 g. Other, (*specify*): (1)

h. None of the above: (1)

79. Were any of the items 78a-g checked:

Yes (* 1) No (2)
☒ 

**Caution: Active substance abuse, such as alcohol or inhaled or injection drugs, in the year prior to screening is exclusionary.*

M. Willingness to use effective birth control methods

80. Are you female and of childbearing potential:

Yes (1) No (2)
☒ **83.**

81. Are you currently pregnant:

Yes (1) No (2)
☒ 

82. Are you currently breast feeding:

Yes (* 1) No (2)
☒ 

**Caution: Patient cannot be breastfeeding at time of randomization.*

83. Are you willing to use effective birth control methods during PIVENS (*ask both males and females*):

Yes (1) No (2)
☒ 

N. Administrative information

84. Study Physician PIN: _____

85. Study Physician signature: _____

86. Clinical Coordinator PIN: _____

87. Clinical Coordinator signature: _____

88. Date form reviewed:

____ day ____ mon ____ year

PIVENS**BG - Baseline History****Purpose:** To collect baseline history information about the patient.**When:** Visit s1.**Administered by:** Clinical Coordinator, reviewed by Study Physician.**Respondent:** Patient.

Instructions: Collect information by interview or chart review. If  is checked for an item, use caution. If the physician agrees with the diagnosis, the patient is ineligible for PIVENS. If  is checked for an item, the patient is ineligible and cannot enroll in PIVENS. The form should not be keyed to the data system, but the form should be retained; set aside with forms for other patients who started screening, but were found to be ineligible.

A. Center, visit, and patient identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date (*date this form is initiated*):

_____ day _____ mon _____ year

5. Visit code: s 1 _____6. Form & revision: b g 27. Study: PIVENS 29. If yes, characterize the liver disease(s)
(*check all that apply*)a. Alcohol related liver disease: (1)b. Viral hepatitis: (1)c. Alpha-1 antitrypsin deficiency: (1)d. Wilson's disease: (1)e. Glycogen storage disease: (1)f. Iron overload: (1)g. Fatty liver disease (*NAFLD, NASH*): (1)h. Primary liver cancer: (1)i. Type of liver disease unknown: (1)j. Other (*specify*): (1)_____
specify**B. Family history**8. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have liver disease:

(Yes) (No)
10. _____

10. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have cirrhosis:

(Yes) (No)
12. _____

11. If yes, is the cause of the cirrhosis
unknown (cryptogenic):

(Yes) (No)

12. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have diabetes (Type 1 or Type 2):Yes (1)No (2)Don't know (3)

13. Do any of the patient's first degree relatives (parent, brother, sister, child) have obesity:

Yes (1)
 No (2)
 Don't know (3)

14. Do any of the patient's first degree relatives (parent, brother, sister, child) have atrophy of body fat:

Yes (1)
 No (2)
 Don't know (3)

15. Do any of the patient's first degree relatives (parent, brother, sister, child) have a problem with cholesterol or blood fat:

Yes (1)
 No (2)
 Don't know (3)

C. NASH history

16. Date patient was first diagnosed with nonalcoholic steatohepatitis (NASH):

____ day ____ mon ____ year

17. What prompted the evaluation for NASH (*check all that apply*)

a. Symptoms for liver disease: (1)
 b. Result of being evaluated for another illness: (1)
 c. During a routine or insurance physical examination: (1)
 d. Blood donation: (1)
 e. Other (*specify*): (1)

 specify

18. What procedures/tests supported this first diagnosis (*check all that apply*)

a. Liver biopsy: (1)
 b. Imaging studies (*Ultrasound, CT, MRI*): (1)
 c. Elevated aminotransferases: (1)
 d. Other (*specify*): (1)

 specify

D. Weight history

19. What was the patient's birthweight:

____ lbs ____ oz

20. Review flashcard 9. Which (picture) best describes your weight pattern over the past 5 years (*check only one*):

Up and down, up and down (1)
 Up gradually (2)
 Up sharply (*gained a lot in a brief interval*) (3)
 Down gradually (4)
 Down sharply (*lost a lot in a brief interval*) (5)
 No or minimal change (6)

21. What is the patient's current weight (*ask the patient for his/her weight*):

____ lbs

22. What is the most the patient has ever weighed:

____ lbs

23. At what age did the patient weigh the most:

____ age in years

24. What is the least the patient has ever weighed since age 18:

____ lbs

25. At what age did the patient weigh the least since age 18:

____ age in years

26. Does the patient weigh more than he/she did one year ago:

(^{Yes}
1) (^{No}
2)
28. _____

27. How much more does the patient weigh now compared to one year ago:

_____ lbs _____

28. Does the patient weigh less than he/she did one year ago:

(^{Yes}
1) (^{No}
2)
30. _____

29. How much less does the patient weigh now compared to one year ago:

_____ lbs _____

30. Did the patient try to lose or gain weight:

(^{Yes}
1) (^{No}
2)
32. _____

31. Which did the patient try to do (*check only one*):

Gain weight (¹)
Lose weight (²)

E. Tobacco cigarette smoking history

(*interview with patient; not by chart review*)

32. Have you ever smoked tobacco cigarettes:

Never (¹)
In the past but not anymore (²)
Currently smokes cigarettes (³)
37. _____

33. Did you smoke cigarettes regularly (*"No" means less than 20 packs of cigarettes in a lifetime or less than 1 cigarette a day for one year*):

(^{Yes}
1) (^{No}
2)
37. _____

34. How old were you when you first started regular cigarette smoking:

_____ years

35. How old were you when you (last) stopped smoking cigarettes (*code as "n" if the patient didn't stop smoking*):

_____ years

36. On the average of the entire time that you smoked cigarettes, how many cigarettes did you smoke per day:

_____ cigarettes/day

F. Menstrual history

37. Is the patient female:

(^{Yes}
1) (^{No}
2)
42. _____

38. What was the patient's age at menarche:

_____ age in years

39. Characterize the menstrual history in the past 5 years (*check only one*):

Regular periods (¹)
Irregular periods (²)
Rare periods (³)
No periods (⁴)

40. Is patient post-menopausal:

(^{Yes}
1) (^{No}
2)
42. _____

41. What was the patient's age at menopause:

_____ age in years

G. Medical history (means *Caution; condition is exclusionary if study physician agrees with diagnosis*)

42. Has the patient ever been diagnosed with or treated for any of the following (*check all that apply; source of information can be interview and/or chart review*)

- a.** Diabetes type 1:  ()
- b.** Diabetes type 2:  ()
- c.** Gestational diabetes (*diabetes of pregnancy*): ()
- d.** Hepatitis B:  ()
- e.** Hepatitis C:  ()
- f.** Autoimmune hepatitis:  ()
- g.** Autoimmune cholestatic liver disorder (PBC or PSC):  ()
- h.** Wilson's disease:  ()
- i.** Alpha-1-antitrypsin (A1AT) deficiency:  ()
- j.** Iron overload:  ()
- k.** Drug induced liver disease:  ()
- l.** Gilbert's syndrome: ()
- m.** Esophageal or gastric varices on endoscopy:  ()
- n.** Bleeding from varices:  ()
- o.** Other gastrointestinal bleeding: ()
- p.** Biliary diversion:  ()
- q.** Ascites:  ()

- r.** Edema: ()
- s.** Hepatic encephalopathy:  ()
- t.** Portal hypertension:  ()
- u.** Hepatorenal syndrome:  ()
- v.** Hepatopulmonary syndrome:  ()
- w.** Short bowel syndrome:  ()
- x.** Hemophilia (*bleeding disorder*):  ()
- y.** Systemic autoimmune disorder such as rheumatoid arthritis or systemic lupus: ()
- z.** Endocrine disease (*hormonal abnormality*): ()
- aa.** Hepatocellular carcinoma:  ()
- ab.** Other malignancy (*cancer*):  ()
- ac.** Human immunodeficiency virus (HIV):  ()
- ad.** Peripheral neuropathy: ()
- ae.** Seizure disorder or epilepsy: ()
- af.** Drug allergies: ()
- ag.** Hypothyroidism: ()
- ah.** Hypertension: ()
- ai.** Cerebrovascular disease: ()
- aj.** Dysbetalipoproteinemia:  ()
- ak.** Hyperlipidemia (*high cholesterol, high triglycerides*): ()
- al.** Pancreatitis: ()
- am.** Cholelithiasis:  ()
- an.** Coronary artery disease:  ()

- ao. Congestive heart failure:  (1)
- ap. Elevated uric acid such as gout: (1)
- aq. Kidney disease: (1)
- ar. Polycystic ovary syndrome: (1)
- as. Sleep apnea (*not breathing during sleep*): (1)
- at. Dermatologic disorders: (1)
- au. Myopathy: (1)
- av. Myositis: (1)
- aw. Major depression: (1)
- ax. Schizophrenia: (1)
- ay. Bipolar disorder: (1)
- az. Obsessive compulsive disorder: (1)
- ba. Severe anxiety or personality disorder: (1)
- bb. Substance abuse:  (1)
- bc. None of the above: (1)
43. Has the patient ever had bariatric surgery for any of the following (*check all that apply*)
- a. Stapling or banding of the stomach:  (1)
- b. Jejunioileal (*or other intestinal*) bypass:  (1)
- c. Biliopancreatic diversion:  (1)
- d. Other GI or bariatric surgery (*specify*): (1)
- _____
- e. None of the above: (1)

44. Organ, limb, or bone marrow transplant

- a. Has the patient ever received a liver transplant:

(Yes) (No)
 (1) (2)


- b. Has the patient ever received any other organ, limb, or bone marrow transplant:

(Yes) (No)
 (1) (2)

45. Has the patient received total parenteral nutrition (TPN) in the past 12 months:

(Yes) (No)
 (1) (2)


46. Is the patient currently undergoing evaluation for bariatric surgery:

(Yes) (No)
 (1) (2)


H. Drugs historically associated with NAFLD

47. Has the patient used any of the following in the past 2 years

- a. Amiodarone (Cordarone, Pacerone): (1)
- b. Demeclocycline (Declomycin): (1)
- c. Divalproex (Depakote): (1)
- d. Doxycycline (Monodox): (1)
- e. Methotrexate (Rheumatrex): (1)
- f. Minocycline (Dynacin, Minocin): (1)
- g. Oxytetracycline (Terramycin): (1)
- h. Tetracycline (Achromycin): (1)
- i. Valproate sodium (Depacon): (1)
- j. Valproic acid (Depakene): (1)
- k. Other known hepatotoxin (*specify*): (1)

- l. None of the above: (1)

48. Were any of the items on 47a-k checked:

(Yes) (No)
 (*) (2)


**Caution: Use of any of these drugs for more than 2 consecutive weeks in the past 2 years is exclusionary.*

49. Has the patient taken any systemic corticosteroids in the past 2 years (*check all that apply*):

- a. Betamethasone sodium (Celestone): (1)
- b. Cortisol: (1)
- c. Cortisone: (1)
- d. Dexamethasone (Decadron): (1)
- e. Hydrocortisone (Hydrocortone): (1)
- f. Methylprednisolone (Solu-Medrol): (1)
- g. Prednisolone (Prelone): (1)
- h. Prednisone: (1)
- i. Triamcinolone (Acetocot, Amcort, Aristocort, Kenacort): (1)
- j. Other, (*specify*): (1)
-
- k. Other, (*specify*): (1)
-
- l. None of the above: (1)

50. Were any of the items 49a-k checked:

Yes (* 1) No (2)



**Caution: Use of systemic glucocorticoids for more than 2 consecutive weeks in the past 2 years is exclusionary.*

51. Has the patient taken any estrogen, progestin, anabolic steroids, hormone replacement therapy, or selective estrogen receptor modulators in the past 2 years (*check all that apply*):

- a. Boldenone undecylenate (Equipose): (1)
- b. Conjugated estrogen (Premarin/Prempro): (1)
- c. Diethylstilbestrol and methyltestosterone (Tylosterone): (1)
- d. Esterified estrogen (Estratab, Menest): (1)
- e. Estradiol (Estrace): (1)
- f. Ethinyl estradiol (Estinyl): (1)
- g. Fluoxymesterone (Android-F, Halotestin): (1)
- h. Levonorgestrel (Norplant): (1)
- i. Medroxyprogesterone (Cycrin, Provera): (1)
- j. Megestrol (Megace): (1)
- k. Methandrostenolone (Dianabol): (1)
- l. Methyltestosterone (Android): (1)
- m. Nandrolone (Deca-Durabolin, Durabolin, Hybolin Decanoate, Kabolin): (1)
- n. Norethindrone (Micronor): (1)
- o. Norgestrel (Ovrette): (1)
- p. Oral contraceptives (Alesse, Demulen, Desogen, Estrostep, Genora, Intercon, Levlen, Levlite, Levora, Loestrin, Lo-Ovral, Necon, Nelova, Nordette, Norethin, Norinyl, Ortho Cyclen, Ortho-Novum, Ortho Tri-Cyclen, Ovral, Tri-Levlen, Triphasil, Trivora, Zovia): (1)
- q. Oxandrolone (Oxandrin): (1)
- r. Oxymetholone (Anadrol): (1)
- s. Progesterone (Prometrium): (1)
- t. Raloxifene (Evista): (1)
- u. Stanzolol (Winstrol): (1)
- v. Tamoxifen (Nolvadex): (1)
- w. Testosterone (Depo-Testosterone): (1)

x. Other, (specify): (1)

y. Other, (specify): (1)

z. None of the above: (1)

52. Were any of the items 51a-y checked:

Yes (* 1) No (2)


**Caution: Use of anabolic steroids, tamoxifen, or estrogens at doses greater than those used for hormone replacement for more than 2 consecutive weeks in the past 2 years is exclusionary.*

I. Use of antidiabetic drugs

53. Does the patient have a known intolerance for thiazolidinediones (rosiglitazone, pioglitazone):

Yes (1) No (2)


54. Has the patient used any antidiabetic medications in the past 12 months (check all that apply):

a. Acarbose (Precose): (1)

b. Acetohexamide (Dymelor): (1)

c. Chlorpropamide (Diabinese): (1)

d. Glimepiride (Amaryl): (1)

e. Glipizide (Glucotrol, Glucotrol XL): (1)

f. Glyburide (Micronase, DiaBeta, Glynase): (1)

g. Insulin: (1)

h. Metformin (Glucophage, Glucophage XR): (1)

i. Miglitol (Glycet): (1)

j. Nateglinide (Starlix): (1)

k. Pioglitazone (Actos): (1)

l. Repaglinide (Prandin): (1)

m. Rosiglitazone (Avandia): (1)

n. Tolazamide (Tolinase): (1)

o. Tolbutamide (Orinase): (1)

p. Other, (specify): (1)

q. None of the above: (1)

55. Were any of the items 54a-p checked:

Yes (* 1) No (2)


**Caution: Use of antidiabetic drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

J. Use of antiNASH drugs and vitamins

56. Has the patient taken any of these antiNASH drugs in the past 12 months (*check all that apply*)

- a.** Betaine (Cystadone): (1)
- b.** Choline + methionine + betaine + adenosine + pyridoxine (Epocler): (1)
- c.** Metformin: (1)
- d.** Ursodeoxycholic acid (UDCA, Actigall, URSO, Ursodiol): (1)
- e.** S-adenylmethionine (SAM-e): (1)
- f.** Milk thistle: (1)
- g.** Probiotics (*any form*): (1)
- h.** Gemfibrozil (Gen-Fibro, Lopid): (1)
- i.** Other (*specify*): (1)

specify

j. None of the above: (1)

57. Were any of the items in 56a-h checked:

(Yes) (No)
(* 1) (2)
C

**Caution: Use of antiNASH drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

58. Has the patient taken any antitumor necrosis factor (anti-TNF) therapies in the past 12 months (*check all that apply*):

- a.** Etanercept (Enbrel): (1)
- b.** Infliximab (Remicade): (1)
- c.** Other, (*specify*): (1)

d. None of the above: (1)

59. Were any of the items 58a-c checked:

(Yes) (No)
(* 1) (2)
C

**Caution: Use of anti-TNF therapies in the 3 months prior to liver biopsy or randomization is exclusionary.*

60. Has the patient taken a multivitamin regularly in the past 12 months:

(Yes) (No)
(1) (2)

61. Has the patient taken any vitamin E (either as a supplement or in a multivitamin) in the past 12 months:

(Yes) (No)
(1) (2)

63.

62. Was/Is the dose of vitamin E greater than 100 IU/day:

(Yes) (No)
(* 1) (2)
C

**Caution: Use of vitamin E at more than 100 IU/day in the 3 months prior to biopsy or randomization is exclusionary.*

63. Is the patient willing to refrain from taking vitamin E in amounts greater than 100 IU/day during PIVENS:

(Yes) (No)
(1) (* 2)
Eng

**Patient may not take vitamin E supplements at doses greater than 100 IU/day during PIVENS.*

64. Does the patient have a known intolerance to vitamin E:

(Yes) (No)
(1) (2)
Eng

65. What other vitamins (other than multivitamins and vitamin E) has the patient taken in the past 12 months (*check all that apply*):

- a.** Vitamin B (any type): (1)
- b.** Vitamin C: (1)
- c.** Vitamin D: (1)
- d.** Other, (*specify*): (1)

e. None of the above: (1)

K. Use of statins, fibrates, and antiobesity drugs

66. Has the patient taken any antihyperlipidemic medications in the past 12 months (*check all that apply*):

- a.** Atorvastatin (Lipitor): (1)
- b.** Colestipol hydrochloride (Colestid): (1)
- c.** Clofibrate (Abitrate, Atromid-S, Claripex, Novofibrate): (1)
- d.** Fenofibrate (Tricor): (1)
- e.** Fluvastatin sodium (Lescol): (1)
- f.** Lovastatin (Mevacor): (1)
- g.** Nicotinic acid (Niaspan): (1)
- h.** Pravastatin sodium (Pravachol): (1)
- i.** Rosuvastatin (Crestor): (1)
- j.** Simvastatin (Zocor): (1)
- k.** Other, (*specify*): (1)

l. None of the above: (1)

67. Were any of the items 66a-k checked:

(Yes) (No)
 (* 1) (2)


**Caution: Use of non-stable doses of statins or fibrates in the 3 months prior to liver biopsy or randomization is exclusionary.*

68. Has the patient taken any antiobesity medications in the past 12 months (*check all that apply*):

- a.** Dexfenfluramine hydrochloride (Redux): (1)
- b.** Fenfluramine hydrochloride (Pondimin): (1)
- c.** Methamphetamine hydrochloride (Desoxyn, Gradumet): (1)
- d.** Orlistat (Xenical): (1)
- e.** Phendimetrazine tartrate (Adipost, Bontril): (1)
- f.** Phentermine hydrochloride (Adipex, Fastin, Ionamin, Teramine): (1)
- g.** Sibutramine hydrochloride monohydrate (Meridia): (1)
- h.** Other, (*specify*): (1)

i. Other, (*specify*): (1)

j. None of the above: (1)

69. Were any of the items 68a-i checked:

(Yes) (No)
 (* 1) (2)


**Caution: Use of antiobesity medications in the 3 months prior to randomization is exclusionary.*

L. Use of other medications and supplements

70. Has the patient taken any cardiovascular or antihypertensive medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Amlodipine besylate (Norvasc): (☐)
- b.** Atenolol (Tenormin): (☐)
- c.** Benazepril (Lotensin): (☐)
- d.** Captopril (Capoten): (☐)
- e.** Clonidine (Catapres): (☐)
- f.** Digoxin (Lanoxin): (☐)
- g.** Diltiazem (Cardizem): (☐)
- h.** Doxazosin (Cardura): (☐)
- i.** Enalapril (Vasotec): (☐)
- j.** Felodipine (Plendil): (☐)
- k.** Furosemide (Lasix): (☐)
- l.** Hydrochlorothiazide (Esidrix, HydroDIURIL): (☐)
- m.** Hydrochlorothiazide + triamterene (Dyazide): (☐)
- n.** Lisinopril (Prinivil, Zestril): (☐)
- o.** Losartan potassium (Cozaar): (☐)
- p.** Losartan potassium with hydrochlorothiazide (Hyzaar): (☐)
- q.** Metoprolol (Lopressor): (☐)
- r.** Nifedipine (Adalat, Procardia): (☐)
- s.** Perhexiline maleate: (☐)
- t.** Propranolol (Inderal): (☐)
- u.** Quinapril (Accupril): (☐)
- v.** Terazosin (Hytrin): (☐)
- w.** Timolol maleate (Blocadren): (☐)
- x.** Valsartan (Diovan): (☐)
- y.** Verapamil (Calan): (☐)
- z.** Other, (*specify*): (☐)

aa. Other, (*specify*): (☐)

ab. None of the above: (☐)

71. Has the patient taken any pain relieving, non-steroidal anti-inflammatory, or aspirin containing medications in the past 12 months (*check all that apply*):

- a.** Acetaminophen (Tylenol): (☐)
- b.** Aspirin - 325 mg: (☐)
- c.** Aspirin - 81 mg: (☐)
- d.** Celecoxib (Celebrex): (☐)
- e.** Ibuprofen (Advil, Motrin): (☐)
- f.** Indomethacin (Indocin): (☐)
- g.** Naproxen (Aleve, Naprosyn): (☐)
- h.** Rofecoxib (Vioxx): (☐)
- i.** Valdecoxib (Bextra): (☐)
- j.** Other, (*specify*): (☐)

k. Other, (*specify*): (☐)

l. Other, (*specify*): (☐)

m. None of the above: (☐)

72. Has the patient taken any strong opiates containing acetaminophen medication in the past 12 months (*check all that apply*):

- a.** Darvocet: (☐)
- b.** Esgic - Plus: (☐)
- c.** Fioricet: (☐)
- d.** Lorcet: (☐)
- e.** Lortab: (☐)
- f.** Norco: (☐)
- g.** Percocet: (☐)
- h.** Talacen: (☐)
- i.** Tylenol #3: (☐)
- j.** Tylenol #4: (☐)
- k.** Tylox: (☐)
- l.** Vicodin: (☐)
- m.** Wygesic: (☐)
- n.** Other, (*specify*): (☐)

o. None of the above: (☐)

73. Has the patient taken any histamine H2 receptor antagonists or other gastrointestinal medications in the past 12 months (*check all that apply*):

- a.** Cimetidine (Tagamet): (☐)
- b.** Esomeprazole magnesium (Nexium): (☐)
- c.** Famotidine (Pepcid): (☐)
- d.** Lansoprazole (Prevacid): (☐)
- e.** Nizatidine (Axid): (☐)
- f.** Omeprazole (Prilosec): (☐)
- g.** Ranitidine (Zantac): (☐)
- h.** Ranitidine bismuth citrate (Tritec): (☐)
- i.** Antacids, (*specify*): (☐)

- j.** Other, (*specify*): (☐)

- k.** Other, (*specify*): (☐)

- l.** None of the above: (☐)

74. Has the patient taken any anticoagulant or antiplatelet medications in the past 12 months (*check all that apply*):

- a.** Clopidogrel (Plavix): (☐)
- b.** Dipyridamole: (☐)
- c.** Heparin: (☐)
- d.** Ticlopidine (Ticlid): (☐)
- e.** Warfarin (Coumadin): (☐)
- f.** Other, (*specify*): (☐)

- g.** Other, (*specify*): (☐)

- h.** None of the above: (☐)

75. Has the patient taken any allergy or asthma medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Albuterol: (☐)
- b.** Beclomethasone dipropionate (Beclovent, Vanceril): (☐)
- c.** Budesonide (Pulmicort, Rhinocort): (☐)
- d.** Fluticasone propionate (Flonase, Flovent): (☐)
- e.** Loratadine (Claritin): (☐)
- f.** Mometasone furoate (Nasonex): (☐)
- g.** Triamcinolone acetonide (Azmecort, Nasacort): (☐)
- h.** Other, (*specify*): (☐)

- i.** Other, (*specify*): (☐)

- j.** None of the above: (☐)

76. Has the patient taken any supplements in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Alpha-lipoic acid: (☐)
- b.** Beta-carotene: (☐)
- c.** Calcium (any form): (☐)
- d.** Carnitine (any form): (☐)
- e.** Chondroitin (any form): (☐)
- f.** Cod liver oil: (☐)
- g.** Coenzyme Q: (☐)
- h.** Dichloroacetate: (☐)
- i.** Echinacea: (☐)
- j.** Fish oil (any form): (☐)
- k.** Flax seed oil: (☐)
- l.** Garlic: (☐)
- m.** Ginkgo biloba: (☐)
- n.** Glucosamine (any form): (☐)
- o.** Lecithin: (☐)
- p.** Magnesium: (☐)
- q.** N-acetyl-cysteine: (☐)
- r.** Potassium (any form): (☐)
- s.** Saw palmetto: (☐)
- t.** Selenium: (☐)
- u.** St. John's Wort: (☐)
- v.** Taurine: (☐)
- w.** Zinc picolinate: (☐)
- x.** Other, (*specify*): (☐)

y. Other, (*specify*): (☐)

z. None of the above: (☐)

77. Has patient taken any of the following medications in the past 12 months (*check all that apply*):

- a.** Isotretinoin (Accutane): (☐)
- b.** Levothyroxine (Levoxyl, Synthroid): (☐)
- c.** Liothyronine (Cytomel): (☐)
- d.** Penicillamine (Cuprimine, Depen): (☐)
- e.** Trientine hydrochloride (Syprine): (☐)
- f.** Other, (*specify*): (☐)

- g.** Other, (*specify*): (☐)

- h.** Other, (*specify*): (☐)

- i.** Other, (*specify*): (☐)

- j.** Other, (*specify*): (☐)

- k.** None of the above: (☐)

78. Has the patient taken any alcohol abuse, inhaled or injection drugs (dependence or withdrawal) medications in the past 12 months (*check all that apply*):

- a. Chlordiazepoxide (Librium): (1)
 b. Clorazepate dipotassium (Tranxene): (1)
 c. Diazepam (Valium): (1)
 d. Disulfiram (Antabuse): (1)
 e. Hydroxyzine pamoate (Vistaril): (1)
 f. Naltrexone hydrochloride (Revia): (1)
 g. Other, (*specify*): (1)

h. None of the above: (1)

79. Were any of the items 78a-g checked:

Yes (* 1) No (2)


**Caution: Active substance abuse, such as alcohol or inhaled or injection drugs, in the year prior to screening is exclusionary.*

M. Willingness to use effective birth control methods

80. Are you female and of childbearing potential:

Yes (1) No (2)
 83. 

81. Are you currently pregnant:

Yes (1) No (2)


82. Are you currently breast feeding:

Yes (* 1) No (2)


**Caution: Patient cannot be breastfeeding at time of randomization.*

83. Are you willing to use effective birth control methods during PIVENS (*ask both males and females*):

Yes (1) No (2)


N. Administrative information

84. Study Physician PIN: _____

85. Study Physician signature: _____

86. Clinical Coordinator PIN: _____

87. Clinical Coordinator signature: _____

88. Date form reviewed:

_____ day _____ mon _____ year

PIVENS

BG - Baseline History

Purpose: To collect baseline history information about the patient.

When: Visit s1.

Administered by: Clinical Coordinator, reviewed by Study Physician.

Respondent: Patient.

Instructions: Collect information by interview or chart review. If $\triangle$ is checked for an item, use caution. If the physician agrees with the diagnosis, the patient is ineligible for PIVENS. If $\otimes$ is checked for an item, the patient is ineligible and cannot enroll in PIVENS. The form should not be keyed to the data system, but the form should be retained; set aside with forms for other patients who started screening, but were found to be ineligible.

A. Center, visit, and patient identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date (date this form is initiated):

_____ day _____ mon _____ year

5. Visit code: s 1 _____

6. Form & revision: b g 3

7. Study: PIVENS 2

9. If yes, characterize the liver disease(s)
(check all that apply)

a. Alcohol related liver disease: (1)

b. Viral hepatitis: (1)

c. Alpha-1 antitrypsin deficiency: (1)

d. Wilson's disease: (1)

e. Glycogen storage disease: (1)

f. Iron overload: (1)

g. Fatty liver disease (NAFLD, NASH): (1)

h. Primary liver cancer: (1)

i. Type of liver disease unknown: (1)

j. Other (specify): (1)

_____ specify

B. Family history

8. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have liver disease:

(Yes) (No)
(1) (2)
10. _____

10. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have cirrhosis:

(Yes) (No)
(1) (2)
12. _____

11. If yes, is the cause of the cirrhosis
unknown (cryptogenic):

(Yes) (No)
(1) (2)

12. Do any of the patient's first degree
relatives (parent, brother, sister, child)
have diabetes (Type 1 or Type 2):

Yes (1)

No (2)

Don't know (3)

13. Do any of the patient's first degree relatives (parent, brother, sister, child) have obesity:

Yes (1)
 No (2)
 Don't know (3)

14. Do any of the patient's first degree relatives (parent, brother, sister, child) have atrophy of body fat:

Yes (1)
 No (2)
 Don't know (3)

15. Do any of the patient's first degree relatives (parent, brother, sister, child) have a problem with cholesterol or blood fat:

Yes (1)
 No (2)
 Don't know (3)

C. NASH history

16. Date patient was first diagnosed with nonalcoholic steatohepatitis (NASH):

____ day ____ mon ____ year

17. What prompted the evaluation for NASH (check all that apply)

a. Symptoms for liver disease: (1)
 b. Result of being evaluated for another illness: (1)
 c. During a routine or insurance physical examination: (1)
 d. Blood donation: (1)
 e. Other (specify): (1)

 specify

18. What procedures/tests supported this first diagnosis (check all that apply)

a. Liver biopsy: (1)
 b. Imaging studies (Ultrasound, CT, MRI): (1)
 c. Elevated aminotransferases: (1)
 d. Other (specify): (1)

 specify

D. Weight history

19. What was the patient's birthweight:

____ lbs ____ oz

20. Review flashcard 9. Which (picture) best describes your weight pattern over the past 5 years (check only one):

Up and down, up and down (1)
 Up gradually (2)
 Up sharply (gained a lot in a brief interval) (3)
 Down gradually (4)
 Down sharply (lost a lot in a brief interval) (5)
 No or minimal change (6)

21. What is the patient's current weight (ask the patient for his/her weight):

____ lbs

22. What is the most the patient has ever weighed:

____ lbs

23. At what age did the patient weigh the most:

____ age in years

24. What is the least the patient has ever weighed since age 18:

____ lbs

25. At what age did the patient weigh the least since age 18:

____ age in years

26. Does the patient weigh more than he/she did one year ago:

(Yes) (No)
(1) (2)
28. _____

27. How much more does the patient weigh now compared to one year ago:

_____ lbs _____

28. Does the patient weigh less than he/she did one year ago:

(Yes) (No)
(1) (2)
30. _____

29. How much less does the patient weigh now compared to one year ago:

_____ lbs _____

30. Did the patient try to lose or gain weight:

(Yes) (No)
(1) (2)
32. _____

31. Which did the patient try to do (*check only one*):

Gain weight (1)
Lose weight (2)

E. Tobacco cigarette smoking history

(*interview with patient; not by chart review*)

32. Have you ever smoked tobacco cigarettes:

Never (1)
In the past but not anymore (2)
Currently smokes cigarettes (3)

33. Did you smoke cigarettes regularly (*"No" means less than 20 packs of cigarettes in a lifetime or less than 1 cigarette a day for one year*):

(Yes) (No)
(1) (2)
37. _____

34. How old were you when you first started regular cigarette smoking:

_____ years

35. How old were you when you (last) stopped smoking cigarettes (*code as "n" if the patient didn't stop smoking*):

_____ years

36. On the average of the entire time that you smoked cigarettes, how many cigarettes did you smoke per day:

_____ cigarettes/day

F. Menstrual history

37. Is the patient female:

(Yes) (No)
(1) (2)
42. _____

38. What was the patient's age at menarche:

_____ age in years

39. Characterize the menstrual history in the past 5 years (*check only one*):

Regular periods (1)
Irregular periods (2)
Rare periods (3)
No periods (4)

40. Is patient post-menopausal:

(Yes) (No)
(1) (2)
42. _____

41. What was the patient's age at menopause:

_____ age in years

G. Medical history (means Caution; condition is exclusionary if study physician agrees with diagnosis)

42. Has the patient ever been diagnosed with or treated for any of the following (check all that apply; source of information can be interview and/or chart review)

- a.** Diabetes type 1:  (1)
- b.** Diabetes type 2:  (1)
- c.** Gestational diabetes (diabetes of pregnancy): (1)
- d.** Hepatitis B:  (1)
- e.** Hepatitis C:  (1)
- f.** Autoimmune hepatitis:  (1)
- g.** Autoimmune cholestatic liver disorder (PBC or PSC):  (1)
- h.** Wilson's disease:  (1)
- i.** Alpha-1-antitrypsin (A1AT) deficiency:  (1)
- j.** Iron overload:  (1)
- k.** Drug induced liver disease:  (1)
- l.** Gilbert's syndrome: (1)
- m.** Esophageal or gastric varices on endoscopy:  (1)
- n.** Bleeding from varices:  (1)
- o.** Other gastrointestinal bleeding: (1)
- p.** Biliary diversion:  (1)
- q.** Ascites:  (1)

- r.** Edema: (1)
- s.** Hepatic encephalopathy:  (1)
- t.** Portal hypertension:  (1)
- u.** Hepatorenal syndrome:  (1)
- v.** Hepatopulmonary syndrome:  (1)
- w.** Short bowel syndrome:  (1)
- x.** Hemophilia (bleeding disorder):  (1)
- y.** Systemic autoimmune disorder such as rheumatoid arthritis or systemic lupus: (1)
- z.** Endocrine disease (hormonal abnormality): (1)
- aa.** Hepatocellular carcinoma:  (1)
- ab.** Other malignancy (cancer):  (1)
- ac.** Human immunodeficiency virus (HIV):  (1)
- ad.** Peripheral neuropathy: (1)
- ae.** Seizure disorder or epilepsy: (1)
- af.** Drug allergies: (1)
- ag.** Hypothyroidism: (1)
- ah.** Hypertension: (1)
- ai.** Cerebrovascular disease: (1)
- aj.** Dysbetalipoproteinemia:  (1)
- ak.** Hyperlipidemia (high cholesterol, high triglycerides): (1)
- al.** Pancreatitis: (1)
- am.** Cholelithiasis:  (1)
- an.** Coronary artery disease:  (1)

- ao.** Congestive heart failure:  (1)
ap. Elevated uric acid such as gout: (1)
aq. Kidney disease: (1)
ar. Polycystic ovary syndrome: (1)
as. Sleep apnea (*not breathing during sleep*): (1)
at. Dermatologic disorders: (1)
au. Myopathy: (1)
av. Myositis: (1)
aw. Major depression: (1)
ax. Schizophrenia: (1)
ay. Bipolar disorder: (1)
az. Obsessive compulsive disorder: (1)
ba. Severe anxiety or personality disorder: (1)
bb. Substance abuse:  (1)
bc. None of the above: (1)
- 43.** Has the patient ever had bariatric surgery for any of the following (*check all that apply*)
a. Stapling or banding of the stomach:  (1)
b. Jejunioileal (*or other intestinal*) bypass:  (1)
c. Biliopancreatic diversion:  (1)
d. Other GI or bariatric surgery (*specify*): (1)

e. None of the above: (1)

44. Organ, limb, or bone marrow transplant

- a.** Has the patient ever received a liver transplant:

Yes (1) No (2)


- b.** Has the patient ever received any other organ, limb, or bone marrow transplant:

Yes (1) No (2)

- 45.** Has the patient received total parenteral nutrition (TPN) in the past 12 months:

Yes (1) No (2)


- 46.** Is the patient currently undergoing evaluation for bariatric surgery:

Yes (1) No (2)


H. Drugs historically associated with NAFLD

- 47.** Has the patient used any of the following in the past 2 years

- a.** Amiodarone (Cordarone, Pacerone): (1)
b. Demeclocycline (Declomycin): (1)
c. Divalproex (Depakote): (1)
d. Doxycycline (Monodox): (1)
e. Methotrexate (Rheumatrex): (1)
f. Minocycline (Dynacin, Minocin): (1)
g. Oxytetracycline (Terramycin): (1)
h. Tetracycline (Achromycin): (1)
i. Valproate sodium (Depacon): (1)
j. Valproic acid (Depakene): (1)
k. Other known hepatotoxin (*specify*): (1)

- l.** None of the above: (1)

- 48.** Were any of the items on 47a-k checked:

Yes (* 1) No (2)


**Caution: Use of any of these drugs for more than 2 consecutive weeks in the past 2 years is exclusionary.*

49. Has the patient taken any systemic corticosteroids in the past 2 years (*check all that apply*):

- a. Betamethasone sodium (Celestone): (1)
- b. Cortisol: (1)
- c. Cortisone: (1)
- d. Dexamethasone (Decadron): (1)
- e. Hydrocortisone (Hydrocortone): (1)
- f. Methylprednisolone (Solu-Medrol): (1)
- g. Prednisolone (Prelone): (1)
- h. Prednisone: (1)
- i. Triamcinolone (Acetocot, Amcort, Aristocort, Kenacort): (1)
- j. Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. None of the above: (1)

50. Were any of the items 49a-k checked:

Yes (* 1) No (2)



**Caution: Use of systemic glucocorticoids for more than 2 consecutive weeks in the past 2 years is exclusionary.*

51. Has the patient taken any estrogen, progestin, anabolic steroids, hormone replacement therapy, or selective estrogen receptor modulators in the past 2 years (*check all that apply*):

- a. Boldenone undecylenate (Equipose): (1)
- b. Conjugated estrogen (Premarin/Prempro): (1)
- c. Diethylstilbestrol and methyltestosterone (Tylosterone): (1)
- d. Esterified estrogen (Estratab, Menest): (1)
- e. Estradiol (Estrace): (1)
- f. Ethinyl estradiol (Estinyl): (1)
- g. Fluoxymesterone (Android-F, Halotestin): (1)
- h. Levonorgestrel (Norplant): (1)
- i. Medroxyprogesterone (Cycrin, Provera): (1)
- j. Megestrol (Megace): (1)
- k. Methandrostenolone (Dianabol): (1)
- l. Methyltestosterone (Android): (1)
- m. Nandrolone (Deca-Durabolin, Durabolin, Hybolin Decanoate, Kabolin): (1)
- n. Norethindrone (Micronor): (1)
- o. Norgestrel (Ovrette): (1)
- p. Oral contraceptives (Alesse, Demulen, Desogen, Estrostep, Genora, Intercon, Levlen, Levlite, Levora, Loestrin, Lo-Ovral, Necon, Nelova, Nordette, Norethin, Norinyl, Ortho Cyclen, Ortho-Novum, Ortho Tri-Cyclen, Ovral, Tri-Levlen, Triphasil, Trivora, Zovia): (1)
- q. Oxandrolone (Oxandrin): (1)
- r. Oxymetholone (Anadrol): (1)
- s. Progesterone (Prometrium): (1)
- t. Raloxifene (Evista): (1)
- u. Stanzolol (Winstrol): (1)
- v. Tamoxifen (Nolvadex): (1)
- w. Testosterone (Depo-Testosterone): (1)

x. Other, (specify): (1)

y. Other, (specify): (1)

z. None of the above: (1)

52. Were any of the items 51a-y checked:

Yes (* 1) No (2)


**Caution: Use of anabolic steroids, tamoxifen, or estrogens at doses greater than those used for hormone replacement for more than 2 consecutive weeks in the past 2 years is exclusionary.*

I. Use of antidiabetic drugs

53. Does the patient have a known intolerance for thiazolidinediones (rosiglitazone, pioglitazone):

Yes (1) No (2)


54. Has the patient used any antidiabetic medications in the past 12 months (check all that apply):

a. Acarbose (Precose): (1)

b. Acetohexamide (Dymelor): (1)

c. Chlorpropamide (Diabinese): (1)

d. Glimepiride (Amaryl): (1)

e. Glipizide (Glucotrol, Glucotrol XL): (1)

f. Glyburide (Micronase, DiaBeta, Glynase): (1)

g. Insulin: (1)

h. Metformin (Glucophage, Glucophage XR): (1)

i. Miglitol (Glycet): (1)

j. Nateglinide (Starlix): (1)

k. Pioglitazone (Actos): (1)

l. Repaglinide (Prandin): (1)

m. Rosiglitazone (Avandia): (1)

n. Tolazamide (Tolinase): (1)

o. Tolbutamide (Orinase): (1)

p. Other, (specify): (1)

q. None of the above: (1)

55. Were any of the items 54a-p checked:

Yes (* 1) No (2)


**Caution: Use of antidiabetic drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

J. Use of antiNASH drugs and vitamins

56. Has the patient taken any of these antiNASH drugs in the past 12 months (*check all that apply*)

- a.** Betaine (Cystadone): (1)
- b.** Choline + methionine + betaine + adenosine + pyridoxine (Epocler): (1)
- c.** Metformin: (1)
- d.** Ursodeoxycholic acid (UDCA, Actigall, URSO, Ursodiol): (1)
- e.** S-adenylmethionine (SAM-e): (1)
- f.** Milk thistle: (1)
- g.** Probiotics (*any form*): (1)
- h.** Gemfibrozil (Gen-Fibro, Lopid): (1)
- i.** Other (*specify*): (1)

_____ specify

j. None of the above: (1)

57. Were any of the items in 56a-h checked:

(Yes ^{*}) (No)
(1) (2)


**Caution: Use of antiNASH drugs in the 3 months prior to liver biopsy or randomization is exclusionary.*

58. Has the patient taken any antitumor necrosis factor (anti-TNF) therapies in the past 12 months (*check all that apply*):

- a.** Etanercept (Enbrel): (1)
- b.** Infliximab (Remicade): (1)
- c.** Other, (*specify*): (1)

d. None of the above: (1)

59. Were any of the items 58a-c checked:

(Yes ^{*}) (No)
(1) (2)


**Caution: Use of anti-TNF therapies in the 3 months prior to liver biopsy or randomization is exclusionary.*

60. Has the patient taken a multivitamin regularly in the past 12 months:

(Yes) (No)
(1) (2)

61. Has the patient taken any vitamin E (either as a supplement or in a multivitamin) in the past 12 months:

(Yes) (No)
(1) (2)

63.

62. Was/Is the dose of vitamin E greater than 100 IU/day:

(Yes ^{*}) (No)
(1) (2)



**Caution: Use of vitamin E at more than 100 IU/day in the 3 months prior to biopsy or randomization is exclusionary.*

63. Is the patient willing to refrain from taking vitamin E in amounts greater than 100 IU/day during PIVENS:

(Yes) (No ^{*})
(1) (2)



**Patient may not take vitamin E supplements at doses greater than 100 IU/day during PIVENS.*

64. Does the patient have a known intolerance to vitamin E:

(Yes) (No)
(1) (2)



65. What other vitamins (other than multivitamins and vitamin E) has the patient taken in the past 12 months (*check all that apply*):

- a.** Vitamin B (any type): (1)
- b.** Vitamin C: (1)
- c.** Vitamin D: (1)
- d.** Other, (*specify*): (1)

e. None of the above: (1)

K. Use of statins, fibrates, and antiobesity drugs

66. Has the patient taken any antihyperlipidemic medications in the past 12 months (*check all that apply*):

- a.** Atorvastatin (Lipitor): (1)
- b.** Colestipol hydrochloride (Colestid): (1)
- c.** Clofibrate (Abitrate, Atromid-S, Claripex, Novofibrate): (1)
- d.** Fenofibrate (Tricor): (1)
- e.** Fluvastatin sodium (Lescor): (1)
- f.** Lovastatin (Mevacor): (1)
- g.** Nicotinic acid (Niaspan): (1)
- h.** Pravastatin sodium (Pravachol): (1)
- i.** Rosuvastatin (Crestor): (1)
- j.** Simvastatin (Zocor): (1)
- k.** Other, (*specify*): (1)

l. None of the above: (1)

67. Were any of the items 66a-k checked:

(Yes) (No)
 (* 1) (2)


**Caution: Use of non-stable doses of statins or fibrates in the 3 months prior to liver biopsy or randomization is exclusionary.*

68. Has the patient taken any antiobesity medications in the past 12 months (*check all that apply*):

- a.** Dexfenfluramine hydrochloride (Redux): (1)
- b.** Fenfluramine hydrochloride (Pondimin): (1)
- c.** Methamphetamine hydrochloride (Desoxyn, Gradumet): (1)
- d.** Orlistat (Xenical): (1)
- e.** Phendimetrazine tartrate (Adipost, Bontril): (1)
- f.** Phentermine hydrochloride (Adipex, Fastin, Ionamin, Teramine): (1)
- g.** Sibutramine hydrochloride monohydrate (Meridia): (1)
- h.** Other, (*specify*): (1)

i. Other, (*specify*): (1)

j. None of the above: (1)

69. Were any of the items 68a-i checked:

(Yes) (No)
 (* 1) (2)


**Caution: Use of antiobesity medications in the 3 months prior to randomization is exclusionary.*

L. Use of other medications and supplements

70. Has the patient taken any cardiovascular or antihypertensive medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Amlodipine besylate (Norvasc): (1)
- b.** Atenolol (Tenormin): (1)
- c.** Benazepril (Lotensin): (1)
- d.** Captopril (Capoten): (1)
- e.** Clonidine (Catapres): (1)
- f.** Digoxin (Lanoxin): (1)
- g.** Diltiazem (Cardizem): (1)
- h.** Doxazosin (Cardura): (1)
- i.** Enalapril (Vasotec): (1)
- j.** Felodipine (Plendil): (1)
- k.** Furosemide (Lasix): (1)
- l.** Hydrochlorothiazide (Esidrix, HydroDIURIL): (1)
- m.** Hydrochlorothiazide + triamterene (Dyazide): (1)
- n.** Lisinopril (Prinivil, Zestril): (1)
- o.** Losartan potassium (Cozaar): (1)
- p.** Losartan potassium with hydrochlorothiazide (Hyzaar): (1)
- q.** Metoprolol (Lopressor): (1)
- r.** Nifedipine (Adalat, Procardia): (1)
- s.** Perhexiline maleate: (1)
- t.** Propranolol (Inderal): (1)
- u.** Quinapril (Accupril): (1)
- v.** Terazosin (Hytrin): (1)
- w.** Timolol maleate (Blocadren): (1)
- x.** Valsartan (Diovan): (1)
- y.** Verapamil (Calan): (1)
- z.** Other, (*specify*): (1)

aa. Other, (*specify*): (1)

ab. None of the above: (1)

71. Has the patient taken any pain relieving, non-steroidal anti-inflammatory, or aspirin containing medications in the past 12 months (*check all that apply*):

- a.** Acetaminophen (Tylenol): (1)
- b.** Aspirin - 325 mg: (1)
- c.** Aspirin - 81 mg: (1)
- d.** Celecoxib (Celebrex): (1)
- e.** Ibuprofen (Advil, Motrin): (1)
- f.** Indomethacin (Indocin): (1)
- g.** Naproxen (Aleve, Naprosyn): (1)
- h.** Rofecoxib (Vioxx): (1)
- i.** Valdecoxib (Bextra): (1)
- j.** Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. Other, (*specify*): (1)

m. None of the above: (1)

72. Has the patient taken any strong opiates containing acetaminophen medication in the past 12 months (*check all that apply*):

- a.** Darvocet: (1)
- b.** Esgic - Plus: (1)
- c.** Fioricet: (1)
- d.** Lorcet: (1)
- e.** Lortab: (1)
- f.** Norco: (1)
- g.** Percocet: (1)
- h.** Talacen: (1)
- i.** Tylenol #3: (1)
- j.** Tylenol #4: (1)
- k.** Tylox: (1)
- l.** Vicodin: (1)
- m.** Wygesic: (1)
- n.** Other, (*specify*): (1)

o. None of the above: ()

73. Has the patient taken any histamine H2 receptor antagonists or other gastrointestinal medications in the past 12 months (*check all that apply*):

- a.** Cimetidine (Tagamet): (☐)
- b.** Esomeprazole magnesium (Nexium): (☐)
- c.** Famotidine (Pepcid): (☐)
- d.** Lansoprazole (Prevacid): (☐)
- e.** Nizatidine (Axid): (☐)
- f.** Omeprazole (Prilosec): (☐)
- g.** Ranitidine (Zantac): (☐)
- h.** Ranitidine bismuth citrate (Tritec): (☐)
- i.** Antacids, (*specify*): (☐)

- j.** Other, (*specify*): (☐)

- k.** Other, (*specify*): (☐)

- l.** None of the above: (☐)

74. Has the patient taken any anticoagulant or antiplatelet medications in the past 12 months (*check all that apply*):

- a.** Clopidogrel (Plavix): (☐)
- b.** Dipyridamole: (☐)
- c.** Heparin: (☐)
- d.** Ticlopidine (Ticlid): (☐)
- e.** Warfarin (Coumadin): (☐)
- f.** Other, (*specify*): (☐)

- g.** Other, (*specify*): (☐)

- h.** None of the above: (☐)

75. Has the patient taken any allergy or asthma medications in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Albuterol: (☐)
- b.** Beclomethasone dipropionate (Beclovent, Vanceril): (☐)
- c.** Budesonide (Pulmicort, Rhinocort): (☐)
- d.** Fluticasone propionate (Flonase, Flovent): (☐)
- e.** Loratadine (Claritin): (☐)
- f.** Mometasone furoate (Nasonex): (☐)
- g.** Triamcinolone acetonide (Azmecort, Nasacort): (☐)
- h.** Other, (*specify*): (☐)

- i.** Other, (*specify*): (☐)

- j.** None of the above: (☐)

76. Has the patient taken any supplements in the past 12 months that have not already been reported on this form (*check all that apply*):

- a.** Alpha-lipoic acid: (☐)
- b.** Beta-carotene: (☐)
- c.** Calcium (any form): (☐)
- d.** Carnitine (any form): (☐)
- e.** Chondroitin (any form): (☐)
- f.** Cod liver oil: (☐)
- g.** Coenzyme Q: (☐)
- h.** Dichloroacetate: (☐)
- i.** Echinacea: (☐)
- j.** Fish oil (any form): (☐)
- k.** Flax seed oil: (☐)
- l.** Garlic: (☐)
- m.** Ginkgo biloba: (☐)
- n.** Glucosamine (any form): (☐)
- o.** Lecithin: (☐)
- p.** Magnesium: (☐)
- q.** N-acetyl-cysteine: (☐)
- r.** Potassium (any form): (☐)
- s.** Saw palmetto: (☐)
- t.** Selenium: (☐)
- u.** St. John's Wort: (☐)
- v.** Taurine: (☐)
- w.** Zinc picolinate: (☐)
- x.** Other, (*specify*): (☐)

y. Other, (*specify*): (☐)

z. None of the above: (☐)

77. Has patient taken any of the following medications in the past 12 months (*check all that apply*):

- a.** Isotretinoin (Accutane): (☐)
- b.** Levothyroxine (Levoxyl, Synthroid): (☐)
- c.** Liothyronine (Cytomel): (☐)
- d.** Penicillamine (Cuprimine, Depen): (☐)
- e.** Trientine hydrochloride (Syprine): (☐)
- f.** Other, (*specify*): (☐)

- g.** Other, (*specify*): (☐)

- h.** Other, (*specify*): (☐)

- i.** Other, (*specify*): (☐)

- j.** Other, (*specify*): (☐)

- k.** None of the above: (☐)

78. Has the patient taken any alcohol abuse, inhaled or injection drugs (dependence or withdrawal) medications in the past 12 months (*check all that apply*):

- a. Chlordiazepoxide (Librium): (☐ 1)
 b. Clorazepate dipotassium (Tranxene): (☐ 1)
 c. Diazepam (Valium): (☐ 1)
 d. Disulfiram (Antabuse): (☐ 1)
 e. Hydroxyzine pamoate (Vistaril): (☐ 1)
 f. Naltrexone hydrochloride (Revia): (☐ 1)
 g. Other, (*specify*): (☐ 1)

h. None of the above: (☐ 1)

79. Were any of the items 78a-g checked:

Yes (☒ * 1) No (☐ 2)


**Caution: Active substance abuse, such as alcohol or inhaled or injection drugs, in the year prior to screening is exclusionary.*

M. Willingness to use effective birth control methods

80. Are you female and of childbearing potential:

Yes (☐ 1) No (☐ 2)
 84. 

81. Are you currently pregnant:

Yes (☐ 1) No (☐ 2)


82. Are you currently breast feeding:

Yes (☒ * 1) No (☐ 2)


**Caution: Patient cannot be breastfeeding at time of randomization.*

83. Are you willing to use effective birth control methods during PIVENS (*ask only females*):

Yes (☐ 1) No (☐ 2)


N. Administrative information

84. Study Physician PIN: _____

85. Study Physician signature: _____

86. Clinical Coordinator PIN: _____

87. Clinical Coordinator signature: _____

88. Date form reviewed:

_____ day _____ mon _____ year

PIVENS**BP - Blood Processing for Plasma and Serum**

Purpose: Document collection of fasting blood for local separation of plasma and serum and shipment to NIDDK Biosample Repository at Fisher BioServices.

When: Visits s2, f016, f032, f048, f064, f080, f096, and f120.

By whom: Clinical Coordinator and laboratory personnel responsible for collection and processing of whole blood.

Instructions: Fill CTAD and SST tubes with whole blood and prepare plasma and serum aliquots in the quantities specified below for the visit. Note that the number of SST tubes used varies by whether or not the patient consented to banking of serum for future research (documented on the Genetic and Future Research Consent Documentation (CG) form (Plasma banking is not affected)).

Visit	All patients		Patients who consent to serum banking for future research		Patient who does NOT consent to serum banking for future research	
	No. of 4.5 mL CTAD tubes to fill	No. of plasma aliquots	No. of 10 mL SST tubes to fill	No. of serum aliquots	No. of 10 mL SST tubes to fill	No. of serum aliquots
s2	1	5 or 6	4	40	1.5	15
f016	none	none	2	20	none	none
f032	none	none	2	20	none	none
f048	1	5 or 6	4	40	1.5	15
f064	none	none	2	20	none	none
f080	none	none	2	20	none	none
f096	1	5 or 6	4	40	1.5	15
f120	1	5 or 6	3	30	1	10

Label CTAD and SST tubes of whole blood using labels specific for the patient and visit; these labels are generated by the clinic upon registration (screening labels) or after randomization (followup visit labels). Attach duplicate whole blood tube labels in items 12 and 14 below. Process blood for plasma and serum within two hours. After separation, prepare 5 or 6 aliquots of plasma, depending on volume of plasma obtained: transfer 0.5 mL of plasma to each of 5 or 6 (2.0 mL) cryovials. After separation, transfer 0.5 mL of serum to each of the 20 or 40 (2.0 mL) cryovials depending on the visit. Label the plasma and serum cryovials with the numbered patient-specific plasma (blue top) and serum (red top) cryovial labels provided by the DCC. Choose one of the cryovial label sets provided by the DCC for this patient for use with this visit. Affix serum aliquot #00 label (all visits) and plasma aliquot #00 label (if visit s2, f048, f096 or f120) to this form in item 19. The LS code keyed from the cryovial labels in item 19 of this form links the cryovials collected today with the date and visit identified in items 4 and 5 of this form. Freeze labeled aliquots of plasma and serum immediately according to procedures specified in the PIVENS SOP, Part I. **NOTE:** Immediately upon completion of plasma and serum aliquot preparation, destroy any leftover cryovial labels from the label set used at this visit; use of these cryovial labels at any other visit will result in aliquots from both visits being unusable since the visit at which they were collected will not be uniquely identified.

A. Center, patient and visit identification

5. Visit code: _____

1. Center code: _____

6. Form & revision: b p 1

2. Patient ID: _____

7. Study: PIVENS 2

3. Patient code: _____

4. Date of visit:

____ - ____ - ____
 day mon year

B. Processing whole blood

Plasma and serum aliquots are to be separated from whole blood per instructions in the SOP. Draw fasting blood in the morning.

8. Was blood collected for the NIDDK Biosample Repository:

Yes (1)

No, patient was not fasting for 12 hours (2)

No, other reason (*specify*): (3)

24. _____

24. _____

specify other reason

9. Date and time of blood draw

- a. Date:

____ day ____ mon ____ year

- b. Time:

____ : ____ (1) (2)
hour minute am pm

10. Was blood collected for plasma banking at this visit (*plasma banking is required at visits s2, f048, f096, and f120*):

(Yes) (No)
(1) (2)

13. _____

11. Number of CTAD (blue-top) tubes: _____

12. Attach duplicate CTAD tube label:

PIVENS Form. BP, Plas.
Pt: 9999, xyz
Visit vvvv
Date: _____

13. Number of SST serum separator (red-top) tubes (4 tubes at visits s2, f048, and f096; 2 tubes at visits f016, f032, f064, and f080; 3 tubes at visit f120): _____

14. Attach duplicate SST serum separator tube labels:

PIVENS Serum 1

Pt: 9999, xyz

Visit: vvvv

BP

Date: _____

PIVENS Serum 2

Pt: 9999, xyz

Visit: vvvv

BP

Date: _____

PIVENS Serum 3

Pt: 9999, xyz

Visit: vvvv

BP

Date: _____

PIVENS Serum 4

Pt: 9999, xyz

Visit: vvvv

BP

Date: _____

15. Phlebotomist:

print name

C. Aliquots for plasma and serum

Pour 0.5 mL of plasma into each of up to six 2.0 mL pre-labeled cryovials and pour 0.5 mL of serum into each of forty 2.0 mL pre-labeled cryovials at visits s2, f048, and f096; 20 pre-labeled cryovials at visits f016, f032, f064, and f080; 30 pre-labeled cryovials at visit f120.

16. Date and time of separation into plasma and serum aliquots

- a. Date:

____ day ____ mon ____ year

- b. Time:

____ : ____ (1) (2)
hour minute am pm

17. Number of aliquots of plasma (*if this was not a plasma banking visit, record "0"*): _____

18. Number of aliquots of serum: _____

19. Attach duplicate cryovial labels
(use aliquot 00 labels which are located in the first row of labels for each label set):

Serum aliquot
#00 label

Plasma aliquot
#00 label

20. Technician:

print name

D. Freezing aliquots

Freeze plasma and serum aliquots immediately at -70°C or -20°C. If frozen at -20°C, the cryovials must be transferred to -70°C within 24 hours. Batch ship monthly to the NIDDK BioSample Repository at Fisher BioServices.

21. Date and time cryovials frozen in -70°C
or -20°C

a. Date: _____ - _____ - _____
day mon year

b. Time: _____ : _____ (1) (2)
hour minute am pm

22. Number of cryovials frozen: _____

23. Technician:

print name

E. Administrative information

24. Clinical Coordinator PIN: _____

25. Clinical Coordinator signature:

26. Date form reviewed:

_____ - _____ - _____
day mon year

CG - Genetic and Future Research Consent Documentation

Purpose: To document consent for use of DNA samples for genetic research and serum, plasma, and liver tissue samples for future research (Duke, CWRU).

When: Visit s2, rz, or as needed during followup (during followup, use visit code of the followup visit that is open).

By whom: Study Physician and Clinical Coordinator.

Instructions: Complete this form based on the consent documents signed by the patient. If the patient changes his/her mind regarding consent for use of samples after the initial form is completed, complete a new CG form.

A. Center, patient and visit identification

1. Center ID: _____

2. Patient ID:

3. Patient code: _____

4. Date form completed:

_____ - _____ - _____
day mon year

5. Visit code:

6. Form & revision: c g 1

7. Study: PIVENS 2

B. Consent for collection, storage, and use of DNA for current and future genetic research

8. Does the patient consent to genetic research on NASH that is currently planned by the study investigators:

☐ Yes ☐ No
☐ 1 ☐ 2

9. Does the patient consent to future genetic research on NASH by this study or other study investigators:

(Yes) (No)

(1) (2)

10. Does the patient consent to future genetic research not related to NASH by this study or other study investigators:

(Yes) (No)

(1) (2)

11. Other information related to consent for genetic research that clinic staff feel needs to be keyed to the study database (*e.g., if your genetic consent had other options that are not covered by the 3 categories of use of samples specified above*):

12. In your judgment, has the patient consented to collection of blood for DNA banking (*this question is asked in recognition that not all IRBs will have approved consent statements that include language that can be mapped into the questions in items 8 through 10; a response of “No” to this question (item 12) means that blood should NOT be collected for sending to the Genetics Repository and if already collected, should be destroyed by the Genetics Repository*):

Yes No
☐ ₁ ☐ ₂

C. Consent for serum, plasma, and liver tissue storage for future research

13. Is this a patient at Duke or CWRU:

Yes No

$\binom{}{1}$ $\binom{}{2}$

15. —

14. Does the patient consent to have his/her serum, plasma, and liver tissue stored for future research:

Yes No
☐ ₁ ☐ ₂

D. Administrative information

15. Study Physician PIN: ____

16. Study Physician signature:

17. Clinical Coordinator PIN: ____

18. Clinical Coordinator signature:

19. Date form reviewed:
____-____-____
day mon year

PIVENS

CR - Central Histology Review

Purpose: Record results of the NASH CRN Pathology Committee review of liver biopsy slides archived at the Histology Review Center.

When: Biopsy slides may have visit code s1, f096, or n.

By whom: Data Coordinating Center staff member.

Instructions: Upon review of the liver biopsy slides by the NASH CRN Pathology Committee, the designated Data Coordinating Center staff member should complete the CR form. The CR form will be keyed by Data Coordinating Center personnel.

A. Center, participant and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of biopsy:

 day mon year

5. Visit code: _____

6. Form & revision: c r 1

7. Study: PIVENS 2

B. Central reading

8. Date of central reading:

 day mon year

9. Which stained slides are available for review (*check all that apply*)

a. H & E: (1)

b. Masson's trichome: (1)

c. Iron: (1)

d. Other (*specify*): (1)

10. Biopsy length: _____
 mm

11. Steatosis (*assume macro, e.g., large and small droplet*)

a. Grade:
 < 5% (0)
 5-33% (1)
 34-66% (2)
 > 66% (3)

b. Location:
 Zone 3 (0)
 Zone 1 (1)
 Azonal (2)
 Panacinar (3)

c. Microvesicular steatosis, contiguous patches:
 Not present (0)
 Present (1)

12. Fibrosis stage (*Masson's trichrome stain*)

0: None (0)
 1a: Mild, zone 3, perisinusoidal (requires trichome) (1)
 1b: Moderate, zone 3, perisinusoidal (easily seen on H&E) (2)
 1c: Portal/periportal only (3)
 2: Zone 3 and periportal, any combination (4)
 3: Bridging (5)
 4: Cirrhosis (6)

13. Inflammation

a. Amount of lobular inflammation:
combines mononuclear, fat
granulomas, and pmn foci:

- 0 (0)
 < 2 under 20x mag (1)
 2-4 under 20x mag (2)
 > 4 under 20x mag (3)

b. Microgranulomas seen:

- Yes (1) No (2)

c. Large lipogranulomas seen:

- Yes (1) No (2)

d. Amount of portal, chronic
inflammation:

- 0: None (0)
 1a: Mild (1)
 1b: More than mild (2)

14. Liver cell injury

a. Ballooning:

- None (0)
 Few (1)
 Many (2)

b. Acidophil bodies:

- Rare (0)
 Many (1)

c. Pigmented macrophages:

- Rare/absent (0)
 Many (1)

d. Megamitochondria:

- Rare/absent (0)
 Many (1)

15. Mallory bodies

- Rare/absent (0)
 Many (1)

16. Glycogen nuclei:

- Rare/absent (0)
 Many (1)

17. Iron stain

a. Hepatocellular grade:

- Absent or barely discernible, 40x (0)
 Barely discernible granules, 20x (1)
 Discrete granules resolved, 10x (2)
 Discrete granules resolved, 4x (3)
 Masses visible by naked eye (4)

b. Hepatocellular iron distribution:

- Periportal (0)
 Periportal and midzonal (1)
 Panacinar (2)
 Zone 3 or nonzonal (3)

c. Sinusoidal lining cell iron grade:

- None (0)
 Mild (1)
 More than mild (2)

d. Sinusoidal lining cell iron distribution:

- Large vessel endothelium only (0)
 Portal/fibrous bands only, but more
than just in large vessel endothelium (1)
 Intraparenchymal only (2)
 Both portal and intraparenchymal (3)

18. Is this steatohepatitis:

- No (1)
 Suspicious/borderline/indeterminate (2)
 Yes, definite (3)

19. Is cirrhosis present:

- Yes (1) No (2)

21. —

**20. In the committee's opinion, is this
cryptogenic cirrhosis:**

- Yes (1) No (2)

21. Other features (check all that apply)

- a.** Mallory's hyaline (r/o cholate stasis): (1)
b. Perisinusoidal fibrosis away from
septa: (1)
c. Hepatocyte ballooning: (1)
d. Megamitochondria: (1)
e. Other (*specify*): (1)

- f.** None: (1)

22. Other comments (*specify*):

C. Administrative information

23. Data Coordinating Center personnel
signature:

24. Date form reviewed:

—	—	—	—	—	—
day		mon		year	

DD - DEXA Scan for Bone Mineral Density

Purpose: To record DEXA scan measurements of bone mineral density.

When: Visits s2, f096, and f120.

Administered by: Clinical coordinator.

Instructions: Transfer the DEXA scan measures from your institutional report to Section C. Attach a copy of the original DEXA report to this form.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit:

_____ - _____

day mon year

5. Visit code:

6. Form & revision: d d 1

7. Study: PIVENS 2

B. DEXA scan information

8. Did the patient have a whole body dual energy x-ray absorptiometry (DEXA) scan:

Yes (1) No (2)

10. ☐ ☐

9. Reason why DEXA scan was not performed (*check all that apply*)

a. Patient is heavier than the allowed weight: ()

b. Scanner is broken: (-1)

c. Other (specify): _____ ()

specify

17. —

10. DEXA scanner used:

Hologic QDR 4500A ()

Hologic QDR 4500W ()

Hologic New Discovery Series 12.3 ()

Hologic Delphi QDR Series ()

Hologic Delphi W ()

Lunar Prodigy ()

Other (specify) ()

specify make & model number

C. DEXA results summary

11. Lumbar spine BMD: _____ g/cm²

12. Pelvis BMD: _____ g/cm²

13. Subtotal bone mineral density: _____ g/cm²

14. Total bone mineral density: _____ g/cm²

15. Total T-score: _____

16. Total Z-score (if available): _____

D. Administrative information

17. Clinical Coordinator PIN: _____

18. Clinical Coordinator signature:

19. Date form reviewed: _____
 _____ day _____ mon _____ year

PIVENS

DR - Death Report

Purpose: To record the report of a patient's death.

When: As soon as clinic is notified of a patient's death.

Administered by: Study Physician and Clinical Coordinator.

Instructions: Complete this form whenever the clinical center is informed of a patient's death. If the death is considered associated or possibly associated with participation in the PIVENS study, complete a Serious Adverse Event (AN) form and follow the directions on Form AN for reporting a serious adverse event in PIVENS.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date form is initiated (date of notice):

_____ day _____ mon _____ year

5. Visit code: n _____

6. Form & revision: d r 1

7. Study: PIVENS 2

10. Place of death:

_____ city/state/country

_____ city/state/country

11. Cause of death

(Study Physician: use whatever knowledge you have and your best medical judgment to best characterize the cause of death; check only one):

Heart disease (1)

Stroke (2)

Liver disease (3)

Malignancy (4)

Other (specify): (5)

_____ specify

_____ specify

Unknown (6)

B. Death information

8. Date of death:

_____ day _____ mon _____ year

9. Source of death report (check all that apply):

a. Patient's family: (1)

b. Friend: (1)

c. Health care provider or NASH CRN staff: (1)

d. Newspaper: (1)

e. Funeral parlor/home: (1)

f. Medical record: (1)

g. Medical examiner: (1)

h. Coroner: (1)

i. Other (specify): (1)

_____ other source

_____ other source

C. Administrative information

12. Study Physician PIN: _____

13. Study Physician signature: _____

14. Clinical Coordinator PIN: _____

15. Clinical Coordinator signature: _____

16. Date form reviewed:

_____ day _____ mon _____ year

PIVENS

DX - DEXA Scan for Body Fat

Purpose: To record DEXA scan measurements.

When: Visits s2 and f096.

Administered by: Clinical coordinator.

Instructions: Transfer the DEXA scan measures from your institutional report to Section C. Attach a copy of the original DEXA report to this form.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit: _____

_____ day _____ mon _____ year

5. Visit code: _____

6. Form & revision: d x 1

7. Study: PIVENS 2

B. DEXA scan information

8. Did the patient have a whole body dual energy x-ray absorptiometry (DEXA) scan:

Yes (1) No (2)
10. _____

9. Reason why DEXA scan was not performed (*check all that apply*)

a. Patient is heavier than the allowed weight: (1)

b. Scanner is broken: (1)

c. Other (*specify*): (1)

_____ specify

13. _____

10. DEXA scanner used:

Hologic QDR 4500A (1)

Hologic QDR 4500W (2)

Hologic New Discovery Series 12.3 (3)

Hologic Delphi QDR Series (4)

Hologic Delphi W (5)

Lunar Prodigy (6)

Other (*specify*) (7)

_____ specify make & model number

C. DEXA results summary**11. Trunk % fat**

(*if your scanner reports both tissue % fat and region % fat, record region % fat on this report*):

_____ • _____
 %

12. Total % fat

(*if your scanner reports both tissue % fat and region % fat, record region % fat on this report*):

_____ • _____
 %

D. Administrative information

13. Clinical Coordinator PIN: _____

14. Clinical Coordinator signature: _____

15. Date form reviewed: _____

_____ day _____ mon _____ year

DX - DEXA Scan for Body Fat

Purpose: To record DEXA scan measurements.

When: Visits s2, f096, and f120.

Administered by: Clinical coordinator.

Instructions: Transfer the DEXA scan measures from your institutional report to Section C. Attach a copy of the original DEXA report to this form.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit:

_____ - _____ - _____
day mon year

5. Visit code: _____

6. Form & revision: d x 2

7. Study: HIVENS

B. DEXA scan information

8. Did the patient have a whole body dual energy x-ray absorptiometry (DEXA) scan:

10. $\begin{pmatrix} \text{Yes} \\ 1 \end{pmatrix}$ $\begin{pmatrix} \text{No} \\ 2 \end{pmatrix}$

9. Reason why DEXA scan was not performed (*check all that apply*)

a. Patient is heavier than the allowed weight: ()

b. Scanner is broken: ()

c. Other (specify): _____ ()

specify

14. _____

10. DEXA scanner used:

Hologic QDR 4500A ()

Hologic QDR 4500W ()

Hologic New Discovery Series 12.3 ()

Hologic Delphi QDR Series ()

Hologic Delphi W ()

Lunar Prodigy ()

Other (specify) ()

specify make & model number

C. DEXA results summary

11. Date of DEXA scan: _____
 _____ day _____ mon _____ year

12. Trunk % fat
(if your scanner reports both tissue % fat and region % fat, record region % fat on this report):

A horizontal number line with a dot placed above the fraction $\frac{0}{0}$.

13. Total % fat
(if your scanner reports both tissue % fat and region % fat, record region % fat on this report):

A horizontal number line with a central point labeled $0/9$. There are tick marks on either side of this point, but no numerical labels are provided for them.

D. Administrative information

14. Clinical Coordinator PIN: _____

15. Clinical Coordinator signature:

16. Date form reviewed: _____
 _____ day _____ mon _____ year

PIVENS

EC - Eligibility Checklist

Purpose: To check eligibility for PIVENS with respect to items not checked elsewhere on PIVENS screening forms and record reasons for ineligibility for patients found to be ineligible.

When: Visit rz.

Administered by: Study Physician and Clinical Coordinator.

Respondent: Patient and Clinical Coordinator.

Instructions: This form may be initiated at any time. If the patient proceeds to randomization, it must be reviewed on the day of randomization. Patients of childbearing potential must complete the randomization day pregnancy test at the clinic on the day of randomization. Patients who are not of childbearing potential may complete the randomization day visit over the telephone. If this is the case, these requirements must be followed:

- (1) If your consent statement has an area for affirmation of consent prior to randomization, the patient should have signed the affirmation at his/her last screening visit.
- (2) The clinical coordinator must confirm with the patient by telephone on the day of randomization, that the patient feels well and continues to consent to randomization.
- (3) The assigned study medication must be mailed to the patient on the day of randomization for delivery the next day.
- (4) The patient should be instructed to start the medications as soon as possible after receipt.

If ☒ is checked for any item, complete the entire form, but note that the patient may not continue in the PIVENS trial. If an item has not been assessed because the patient is ineligible, write "m" (missing) next to that item. This form should be keyed for each patient for whom form RG was completed.

A. Center, patient, visit, and study identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date (*date this form is initiated*):

____ day ____ mon ____ year

5. Visit code: r z _____

6. Form & revision: e c 1

7. Study: PIVENS 2

B. Alcohol use exclusion

8. On average, has the patient consumed more than 30 g/day of alcohol (males) or 20 g/day of alcohol (females) for a period of more than 3 consecutive months in the 5 years prior to screening:

(Yes) (No)
(1) (2)
☒ Elg

9. In the judgment of the Study Physician and/or Clinical Coordinator, can the patient reliably quantify his/her (*past and current*) alcohol intake:

(Yes) (No)
(1) (2)
☒ Elg

10. In the judgment of the Study Physician and/or Clinical Coordinator, is the patient's alcohol use since starting the screening process consistent with PIVENS eligibility criteria:

(Yes) (No)
(1) (2)
☒ Elg

C. Cirrhosis exclusion**11. Clinical cirrhosis evaluation**

- a. Does the patient have varices or ascites and does the physician judge that the patient has cirrhosis:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- b. In the Study Physician's judgment, does the patient have cirrhosis
(Use histologic, clinical, and laboratory findings such as INR > 1.3, albumin < 3.0 g/dL, or conjugated bilirubin > 2 mg/dL as guidelines):

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

D. Other chronic liver disease exclusions**12. Evidence of autoimmune liver disease**

- a. Does the patient have ongoing autoimmune liver disease defined by the presence of anti-nuclear antibody (ANA) of greater than 1:80 and liver histology consistent with autoimmune liver disease:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- b. In the Study Physician's judgment, does the patient have a history of autoimmune hepatitis:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- 13.** Does the patient have primary biliary cirrhosis defined by alkaline phosphatase above the upper limit of normal and anti-mitochondrial antibody (AMA) of greater than 1:80 and liver histology consistent with primary biliary cirrhosis:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- 14.** Does the patient have known primary sclerosing cholangitis and suggestive liver histology:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- 15.** Does the patient have Wilson's disease defined by ceruloplasmin below the lower limit of normal and liver histology consistent with Wilson's disease:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- 16.** Does the patient have alpha-1-antitrypsin (A1AT) deficiency defined by a suggestive liver histology confirmed by A1AT level less than normal (physician judgment):

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

17. Hemochromatosis

- a. Does the patient have a history of hemochromatosis:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- b. Does the patient have a iron overload as defined by presence of 3+ or 4+ stainable iron on liver biopsy:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- 18.** Do any of the patient's assessments show evidence of other chronic liver disease

- a. Drug induced liver disease as defined on the basis of typical exposure and history:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- b. Known bile duct obstruction:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- c. Suspected or proven liver cancer:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

- d. Any other type of liver disease other than NASH that warrants exclusion from the trial:

(Yes) (No)
(1) (2)
☐ ☒ **Elig**

E. Other medical exclusions**19.** History of diabetes mellitus:

Yes ()
 No ()
 Elig

20. History of bariatric surgery (*jejunoileal bypass or gastric weight loss surgery*):

Yes ()
 No ()
 Elig

21. History of biliary diversion:

Yes ()
 No ()
 Elig

22. Known positivity for antibody to Human Immunodeficiency Virus (HIV):

Yes ()
 No ()
 Elig

23. Known heart failure of New York Heart Association class 2, 3, or 4:

Yes ()
 No ()
 Elig

24. Inability to safely undergo liver biopsy:

Yes ()
 No ()
 Elig

25. Use of drugs associated with NAFLD for more than 2 consecutive weeks in the 2 years prior to screening:

Yes ()
 No ()
 Elig

26. Use of antidiabetic drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

27. Use of antiNASH drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

28. Use of a VARIABLE dose of any statins or fibrates in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

29. Use of antiobesity drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

30. Use of Vitamin E at a dose greater than 100 IU/day:

Yes ()
 No ()
 Elig

31. Known active, serious medical disease with a likely life-expectancy less than 5 years:

Yes ()
 No ()
 Elig

32. Known active substance abuse, such as alcohol or inhaled or injection drugs in the year prior to screening:

Yes ()
 No ()
 Elig

33. Other condition which, in the opinion of the investigator, would impede compliance or hinder completion of the study:

Yes ()
 No ()
 Elig

F. Birth control exclusion

34. In the judgment of the Study Physician and/or Clinical Coordinator, is the patient (*male or female*) willing to use effective birth control methods to avoid pregnancy during the 96 weeks of treatment:

(Yes ☐ 1) (No ☐ 2)


G. Eligibility check on day of randomization

(*do in person if patient is of childbearing potential; otherwise, these checks may be done over the telephone with the patient on the day of randomization*)

35. Was an ineligibility condition checked or an eligibility not ascertained in items 8-34:

(Yes ☐ 1) (No ☐ 2)
 44. _____

**Key visits s1 and s2 forms RG, AD, BC, BD, BG, BP, CG, DX, HF, HS (if needed), LD, LQ, LR, LS, PA, PE, PF, QF. Run the Randomization Task on your clinic data system.*

36. Were any stops or ineligible conditions other than "missing form EC" identified by the Randomization Task:

Yes (☐ 1)
 44. _____
 No (☐ 2)
 Task not run because patient is known to be ineligible (☐ 3)
 44. _____

37. Does the patient feel well today:

(Yes ☐ 1) (No ☐ 2)


**Defer randomization until the patient feels well; when the patient returns to attempt randomization again, review all items on this form and update each item as needed.*

38. Is the patient male:

(Yes ☐ 1) (No ☐ 2)
 42. _____

39. Is the patient of childbearing potential:

(Yes ☐ 1) (No ☐ 2)
 41. _____

**Administer pregnancy test.*

40. Is the patient pregnant (*positive pregnancy test on the day of randomization*):

(Yes ☐ 1) (No ☐ 2)


**Go to item 44.*

41. Is the patient currently breast feeding

(Yes ☐ 1) (No ☐ 2)


**Go to item 44.*

42. Per the Study Physician's judgment, is there any reason to exclude the patient from randomization:

(Yes ☐ 1) (No ☐ 2)


**If Yes, specify reason and then go to item 44:*

_____ specify reason

43. Does the patient still consent to randomization (*you should ask the patient to orally affirm his/her consent*):

(Yes ☐ 1) (No ☐ 2)
 45. _____


**Go to item 45 and complete this form. Then key this form and run the Randomization Task on your clinic data system to randomize the patient.*

†Complete items 44-49 and key the form. The form must be keyed to document the reasons for ineligibility for PIVENS.

H. Reasons for ineligibility for ineligible patients

Note: Complete this section for ineligible patients only.

44. Reason for ineligibility (check all that apply)

- a. Reason covered in items 8-43: (☐)
- b. Biopsy out of window and patient chose not to repeat: (☐)
- c. Biopsy inadequate for scoring and patient chose not to repeat: (☐)
- d. Local pathologist did not find steatohepatitis: (☐)
- e. NAS score ≤ 3 or at least 1 subscore = 0: (☐)
- f. NAS = 4 and central review did not find steatohepatitis: (☐)
- g. Albumin < 3 g/dL: (☐)
- h. INR > 1.3 : (☐)
- i. Bilirubin > 2 mg/dL: (☐)
- j. Positive for hepatitis B: (☐)
- k. Positive for hepatitis C: (☐)
- l. ALT > 300 U/L: (☐)
- m. Fasting blood glucose ≥ 126 mg/dL: (☐)
- n. Creatinine > 2.0 mg/dL: (☐)
- o. Known intolerance to TZDs: (☐)
- p. Known intolerance to vitamin E: (☐)
- q. Liver transplant: (☐)
- r. Currently being evaluated for bariatric surgery: (☐)
- s. TPN in year prior to screening: (☐)
- t. Tests are outside time window and clinic chose not to repeat tests: (☐)
- u. Other reason not covered on this form (specify): (☐)

specify

I. Administrative information

45. Study Physician PIN: _____

46. Study Physician signature: _____

47. Clinical Coordinator PIN: _____

48. Clinical Coordinator signature: _____

49. Date form reviewed

(Note re: patient proceeding to randomization: this form must be reviewed on the day of randomization; if it was keyed prior to the randomization day, update it and re-review it on the day of randomization and key the revised date of review.)

____ - ____ - ____
day mon year

(NOTE: If patient was not present in the clinic to receive the assigned medication, send the medication to the patient by overnight delivery service.)

PIVENS

EC - Eligibility Checklist

Purpose: To check eligibility for PIVENS with respect to items not checked elsewhere on PIVENS screening forms and record reasons for ineligibility for patients found to be ineligible.

When: Visit rz.

Administered by: Study Physician and Clinical Coordinator.

Respondent: Patient and Clinical Coordinator.

Instructions: This form may be initiated at any time. If the patient proceeds to randomization, it must be reviewed on the day of randomization. Patients of childbearing potential must complete the randomization day pregnancy test at the clinic on the day of randomization. Patients who are not of childbearing potential may complete the randomization day visit over the telephone. If this is the case, these requirements must be followed:

- (1) If your consent statement has an area for affirmation of consent prior to randomization, the patient should have signed the affirmation at his/her last screening visit.
- (2) The clinical coordinator must confirm with the patient by telephone on the day of randomization, that the patient feels well and continues to consent to randomization.
- (3) The assigned study medication must be mailed to the patient on the day of randomization for delivery the next day.
- (4) The patient should be instructed to start the medications as soon as possible after receipt.

If ☒ is checked for any item, complete the entire form, but note that the patient may not continue in the PIVENS trial. If an item has not been assessed because the patient is ineligible, write "m" (missing) next to that item. This form should be keyed for each patient for whom form RG was completed.

A. Center, patient, visit, and study identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date (*date this form is initiated*):

____ day ____ mon ____ year

5. Visit code: r z _____

6. Form & revision: e c 1

7. Study: PIVENS 2

B. Alcohol use exclusion

8. On average, has the patient consumed more than 30 g/day of alcohol (males) or 20 g/day of alcohol (females) for a period of more than 3 consecutive months in the 5 years prior to screening:

(Yes ☐ 1) (No ☐ 2)
☒ Elg

9. In the judgment of the Study Physician and/or Clinical Coordinator, can the patient reliably quantify his/her (*past and current*) alcohol intake:

(Yes ☐ 1) (No ☐ 2)
☒ Elg

10. In the judgment of the Study Physician and/or Clinical Coordinator, is the patient's alcohol use since starting the screening process consistent with PIVENS eligibility criteria:

(Yes ☐ 1) (No ☐ 2)
☒ Elg

C. Cirrhosis exclusion**11. Clinical cirrhosis evaluation**

- a.** Does the patient have varices or ascites and does the physician judge that the patient has cirrhosis:

(Yes) (No)
(1) (2)
Elig

- b.** In the Study Physician's judgment, does the patient have cirrhosis
(Use histologic, clinical, and laboratory findings such as INR > 1.3, albumin < 3.0 g/dL, or conjugated bilirubin > 2 mg/dL as guidelines):

(Yes) (No)
(1) (2)
Elig

D. Other chronic liver disease exclusions**12. Evidence of autoimmune liver disease**

- a.** Does the patient have ongoing autoimmune liver disease defined by the presence of anti-nuclear antibody (ANA) of greater than 1:80 and liver histology consistent with autoimmune liver disease:

(Yes) (No)
(1) (2)
Elig

- b.** In the Study Physician's judgment, does the patient have a history of autoimmune hepatitis:

(Yes) (No)
(1) (2)
Elig

- 13.** Does the patient have primary biliary cirrhosis defined by alkaline phosphatase above the upper limit of normal and anti-mitochondrial antibody (AMA) of greater than 1:80 and liver histology consistent with primary biliary cirrhosis:

(Yes) (No)
(1) (2)
Elig

- 14.** Does the patient have known primary sclerosing cholangitis and suggestive liver histology:

(Yes) (No)
(1) (2)
Elig

- 15.** Does the patient have Wilson's disease defined by ceruloplasmin below the lower limit of normal and liver histology consistent with Wilson's disease:

(Yes) (No)
(1) (2)
Elig

- 16.** Does the patient have alpha-1-antitrypsin (A1AT) deficiency defined by a suggestive liver histology confirmed by A1AT level less than normal (physician judgment):

(Yes) (No)
(1) (2)
Elig

17. Hemochromatosis

- a.** Does the patient have a history of hemochromatosis:

(Yes) (No)
(1) (2)
Elig

- b.** Does the patient have a iron overload as defined by presence of 3+ or 4+ stainable iron on liver biopsy:

(Yes) (No)
(1) (2)
Elig

- 18.** Do any of the patient's assessments show evidence of other chronic liver disease

- a.** Drug induced liver disease as defined on the basis of typical exposure and history:

(Yes) (No)
(1) (2)
Elig

- b.** Known bile duct obstruction:

(Yes) (No)
(1) (2)
Elig

- c.** Suspected or proven liver cancer:

(Yes) (No)
(1) (2)
Elig

- d.** Any other type of liver disease other than NASH that warrants exclusion from the trial:

(Yes) (No)
(1) (2)
Elig

E. Other medical exclusions**19.** History of diabetes mellitus:

Yes ()
 No ()
 Elig

20. History of bariatric surgery (*jejunoileal bypass or gastric weight loss surgery*):

Yes ()
 No ()
 Elig

21. History of biliary diversion:

Yes ()
 No ()
 Elig

22. Known positivity for antibody to Human Immunodeficiency Virus (HIV):

Yes ()
 No ()
 Elig

23. Known heart failure of New York Heart Association class 2, 3, or 4:

Yes ()
 No ()
 Elig

24. Inability to safely undergo liver biopsy:

Yes ()
 No ()
 Elig

25. Use of drugs associated with NAFLD for more than 2 consecutive weeks in the 2 years prior to screening:

Yes ()
 No ()
 Elig

26. Use of antidiabetic drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

27. Use of antiNASH drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

28. Use of a VARIABLE dose of any statins or fibrates in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

29. Use of antiobesity drugs in the 3 months prior to randomization:

Yes ()
 No ()
 Elig

30. Use of Vitamin E at a dose greater than 100 IU/day:

Yes ()
 No ()
 Elig

31. Known active, serious medical disease with a likely life-expectancy less than 5 years:

Yes ()
 No ()
 Elig

32. Known active substance abuse, such as alcohol or inhaled or injection drugs in the year prior to screening:

Yes ()
 No ()
 Elig

33. Other condition which, in the opinion of the investigator, would impede compliance or hinder completion of the study:

Yes ()
 No ()
 Elig

F. Birth control exclusion

34. In the judgment of the Study Physician and/or Clinical Coordinator, is the patient (*females of childbearing potential*) willing to use effective birth control methods to avoid pregnancy during the 96 weeks of treatment (*check "Yes" if patient is male or not of childbearing potential*):

(^{Yes}
(^{*}₁) (^{No}
(₂)

41. 

G. Eligibility check on day of randomization

(*do in person if patient is of childbearing potential; otherwise, these checks may be done over the telephone with the patient on the day of randomization*)

35. Was an ineligibility condition checked or an eligibility not ascertained in items 8-34:

(^{Yes}
(^{*}₁) (^{No}
(^{*}₂)

44. _____

**Key visits s1 and s2 forms RG, AD, BC, BD, BG, BP, CG, DX, HF, HS (if needed), LD, LQ, LR, LS, PA, PE, PF, QF. Run the Randomization Task on your clinic data system.*

36. Were any stops or ineligible conditions other than "missing form EC" identified by the Randomization Task:

Yes (¹)

44. _____

No (²)

Task not run because patient is known to be ineligible (³)

44. _____

37. Does the patient feel well today:

(^{Yes}
(^{*}₁) (^{No}
(^{*}₂)



**Defer randomization until the patient feels well; when the patient returns to attempt randomization again, review all items on this form and update each item as needed.*

38. Is the patient male:

(^{Yes}
(^{*}₁) (^{No}
(₂)

42. _____

39. Is the patient of childbearing potential:

(^{Yes}
(^{*}₁) (^{No}
(₂)

41. _____

**Administer pregnancy test.*

40. Is the patient pregnant (*positive pregnancy test on the day of randomization*):

(^{Yes}
(^{*}₁) (^{No}
(₂)



**Go to item 44.*

41. Is the patient currently breast feeding

(^{Yes}
(^{*}₁) (^{No}
(₂)



**Go to item 44.*

42. Per the Study Physician's judgment, is there any reason to exclude the patient from randomization:

(^{Yes}
(^{*}₁) (^{No}
(₂)



**If Yes, specify reason and then go to item 44:*

specify reason

43. Does the patient still consent to randomization (*you should ask the patient to orally affirm his/her consent*):

(^{Yes}
(^{*}₁) (^{No}
([†]₂)

45. _____ 

**Go to item 45 and complete this form. Then key this form and run the Randomization Task on your clinic data system to randomize the patient.*

†Complete items 44-49 and key the form. The form must be keyed to document the reasons for ineligibility for PIVENS.

H. Reasons for ineligibility for ineligible patients

Note: Complete this section for ineligible patients only.

44. Reason for ineligibility (check all that apply)

- a. Reason covered in items 8-43: (☐)
- b. Biopsy out of window and patient chose not to repeat: (☐)
- c. Biopsy inadequate for scoring and patient chose not to repeat: (☐)
- d. Local pathologist did not find steatohepatitis: (☐)
- e. NAS score ≤ 3 or at least 1 subscore = 0: (☐)
- f. NAS = 4 and central review did not find steatohepatitis: (☐)
- g. Albumin < 3 g/dL: (☐)
- h. INR > 1.3 : (☐)
- i. Bilirubin > 2 mg/dL: (☐)
- j. Positive for hepatitis B: (☐)
- k. Positive for hepatitis C: (☐)
- l. ALT > 300 U/L: (☐)
- m. Fasting blood glucose ≥ 126 mg/dL: (☐)
- n. Creatinine > 2.0 mg/dL: (☐)
- o. Known intolerance to TZDs: (☐)
- p. Known intolerance to vitamin E: (☐)
- q. Liver transplant: (☐)
- r. Currently being evaluated for bariatric surgery: (☐)
- s. TPN in year prior to screening: (☐)
- t. Tests are outside time window and clinic chose not to repeat tests: (☐)
- u. Other reason not covered on this form (specify): (☐)

specify

I. Administrative information

45. Study Physician PIN: _____

46. Study Physician signature: _____

47. Clinical Coordinator PIN: _____

48. Clinical Coordinator signature: _____

49. Date form reviewed

(Note re: patient proceeding to randomization: this form must be reviewed on the day of randomization; if it was keyed prior to the randomization day, update it and re-review it on the day of randomization and key the revised date of review.)

____ - ____ - ____
day mon year

(NOTE: If patient was not present in the clinic to receive the assigned medication, send the medication to the patient by overnight delivery service.)

PIVENS

HI - Followup Medical History

Purpose: To record followup medical history information about the patient.

When: Visits f004, f008, f016, f024, f032, f048, f064, f072, f080, f096, and f120.

Administered by: Clinical Coordinator, reviewed by Study Physician.

Respondent: Patient.

Instructions: Collect information by interview or chart review.

A. Center, visit, and patient identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date: _____
 day mon year

5. Visit code: _____

6. Form & revision: h i 1

7. Study: PIVENS 2

B. Interval identification

8. Date of last Followup Medical History form (if this is visit f004 then date of s1):

_____ day mon year

9. Visit code of last Followup Medical History form (if this is visit f004 then s1):

C. NASH evaluation

10. Has the patient had a liver biopsy since the last visit:

Yes No
 (*) (2)

*Complete the Liver Biopsy Materials Documentation (SD) form.

D. Alcohol consumption (AUDIT-C) since the last visit (interview with patient)

11. Since the last visit, how often have you had a drink containing alcohol:

Never (0)

Monthly or less (1)

Two to four times a month (2)

Two to three times a week (3)

Four or more times a week (4)

12. Since the last visit, how many drinks containing alcohol did you have on a typical day when you are drinking:

1 or 2 (0)

3 or 4 (1)

5 or 6 (2)

7 to 9 (3)

10 or more (4)

13. Since the last visit, how often have you had six or more drinks on one occasion:

Never (0)

Less than monthly (1)

Monthly (2)

Weekly (3)

Daily or almost daily (4)

14. _____

E. Tobacco cigarette smoking (interview with patient)

14. Since the last visit, have you smoked tobacco cigarettes regularly (“No” means less than 1 day per week on average):

Yes No
 (1) (2)
 17. —————

15. On average, how many days per week have you smoked cigarettes: _____
days

16. On the days that you smoked, about how many cigarettes did you smoke per day: _____
cigarettes per day

F. Medical history

17. Since the last visit, has the patient been diagnosed with or treated for any of the following (check all that apply; source of information can be interview and/or chart review; complete an Interim Event Report (IE) form, if any of the conditions checked are possibly or definitely associated with PIVENS study drugs and the event has not already been reported on an IE form)

- a. Diabetes type 1: (1)
- b. Diabetes type 2: (1)
- c. Gestational diabetes (diabetes of pregnancy): (1)
- d. Hepatitis B: (1)
- e. Hepatitis C: (1)
- f. Autoimmune hepatitis: (1)
- g. Autoimmune cholestatic liver disorder (PBC or PSC): (1)
- h. Wilson’s disease: (1)
- i. Alpha-1-antitrypsin (A1AT) deficiency: (1)
- j. Iron overload: (1)
- k. Drug induced liver disease: (1)
- l. Gilbert’s syndrome: (1)
- m. Esophageal or gastric varices on endoscopy: (1)
- n. Bleeding from varices: (1)
- o. Other gastrointestinal bleeding: (1)
- p. Biliary diversion: (1)

- q.** Ascites: (1)
r. Edema: (1)
s. Hepatic encephalopathy: (1)
t. Portal hypertension: (1)
u. Hepatorenal syndrome: (1)
v. Hepatopulmonary syndrome: (1)
w. Short bowel syndrome: (1)
x. Hemophilia (*bleeding disorder*): (1)
y. Systemic autoimmune disorder such as rheumatoid arthritis or systemic lupus: (1)
z. Endocrine disease (*hormonal abnormality*): (1)
aa. Hepatocellular carcinoma: (1)
ab. Other malignancy (*cancer*): (1)
ac. Human immunodeficiency virus (HIV): (1)
ad. Peripheral neuropathy: (1)
ae. Seizure disorder or epilepsy: (1)
af. Drug allergies: (1)
ag. Hypothyroidism: (1)
ah. Hypertension: (1)
ai. Cerebrovascular disease: (1)
aj. Dysbetalipoproteinemia: (1)
ak. Hyperlipidemia (*high cholesterol, high triglycerides*): (1)
al. Pancreatitis: (1)
am. Cholelithiasis: (1)
an. Coronary artery disease: (1)
ao. Congestive heart failure: (1)
ap. Elevated uric acid such as gout: (1)
aq. Kidney disease: (1)
ar. Polycystic ovary syndrome: (1)
as. Sleep apnea (*not breathing during sleep*): (1)
at. Dermatologic disorders: (1)
au. Myopathy: (1)
av. Myositis: (1)
aw. Major depression: (1)
ax. Schizophrenia: (1)
ay. Bipolar disorder: (1)
az. Obsessive compulsive disorder: (1)
ba. Severe anxiety or personality disorder: (1)
bb. Substance abuse: (1)
bc. None of the above: (1)
- 18.** Since the last visit, has the patient had bariatric surgery for any of the following (*check all that apply*)
a. Stapling or banding of the stomach: (1)
b. Jejunioleal (*or other intestinal*) bypass: (1)
c. Biliopancreatic diversion: (1)
d. Other GI or bariatric surgery, (*specify*): (1)

e. None of the above: (1)
- 19.** Since the last visit, has the patient received an organ, limb, or bone marrow transplant:
 Yes (1) No (2)
- 20.** Since the last visit, has the patient received total parenteral nutrition (TPN):
 Yes (1) No (2)
- 21.** Since the last visit, has the patient been hospitalized (*complete an Interim Event Report (IE) form if possibly or definitely associated with PIVENS study drugs and this event has not already been reported on an IE form*) :
 Yes (1) No (2)
 22. _____
 If Yes, specify reason:

 specify

22. Since the last visit, has the patient had any other health problem not already reported (*complete an Interim Event Report (IE) form if possibly or definitely associated with PIVENS study drugs and the event has not already been reported on an IE form*):

Yes
(1)
No
(2)

23.

If Yes, specify:

_____ specify

G. Medication use

23. Since the last visit, has the patient used any antidiabetic medications (*check all that apply*):

- a. Acarbose (Precose): (1)
- b. Acetohexamide (Dymelor): (1)
- c. Chlorpropamide (Diabinese): (1)
- d. Glimepiride (Amaryl): (1)
- e. Glipizide (Glucotrol, Glucotrol XL): (1)
- f. Glyburide (Micronase, DiaBeta, Glynase): (1)
- g. Insulin: (1)
- h. Metformin (Glucophage, Glucophage XR): (1)
- i. Miglitol (Glycet): (1)
- j. Nateglinide (Starlix): (1)
- k. Pioglitazone (Actos) (*do not include PIVENS study medication*): (1)
- l. Repaglinide (Prandin): (1)
- m. Rosiglitazone (Avandia): (1)
- n. Tolazamide (Tolinase): (1)
- o. Tolbutamide (Orinase): (1)
- p. Other, (*specify*): (1)

q. None of the above: (1)

24. Since the last visit, has the patient taken any alcohol abuse (dependence or withdrawal) medications (*check all that apply*):

- a. Chlordiazepoxide (Librium): (1)
- b. Clorazepate dipotassium (Tranxene): (1)
- c. Diazepam (Valium): (1)
- d. Disulfiram (Antabuse): (1)
- e. Hydroxyzine pamoate (Vistaril): (1)
- f. Naltrexone hydrochloride (Revia): (1)
- g. Other, (*specify*): (1)

h. None of the above: (1)

25. Since the last visit, has the patient taken any antihyperlipidemic medications (*check all that apply*):

- a. Atorvastatin (Lipitor): (1)
- b. Colestipol hydrochloride (Colestid): (1)
- c. Clofibrate (Abitrate, Atromid-S, Claripex, Novofibrate): (1)
- d. Gemfibrozil (Gen-Fibro, Lopid): (1)
- e. Fenofibrate (Tricor): (1)
- f. Fluvastatin sodium (Lescol): (1)
- g. Lovastatin (Mevacor): (1)
- h. Nicotinic acid (Niaspan): (1)
- i. Pravastatin sodium (Pravachol): (1)
- j. Rosuvastatin (Crestor): (1)
- k. Simvastatin (Zocor): (1)
- l. Other, (*specify*): (1)

m. None of the above: (1)

26. Since the last visit, has the patient taken any antiobesity medications (*check all that apply*):

- a. Dexfenfluramine hydrochloride (Redux): (1)
- b. Fenfluramine hydrochloride (Pondimin): (1)
- c. Methamphetamine hydrochloride (Desoxyn, Gradumet): (1)
- d. Orlistat (Xenical): (1)
- e. Phendimetrazine tartrate (Adipost, Bontril): (1)
- f. Phentermine hydrochloride (Adipex, Fastin, Ionamin, Teramine): (1)
- g. Sibutramine hydrochloride monohydrate (Meridia): (1)
- h. Other, (*specify*): (1)

i. Other, (*specify*): (1)

j. None of the above: (1)

27. Since the last visit, has the patient taken any antitumor necrosis factor (anti-TNF) therapies (*check all that apply*):

- a. Etanercept (Enbrel): (1)
- b. Infliximab (Remicade): (1)
- c. Other, (*specify*): (1)

specify

d. None of the above: (1)

28. Since the last visit, has the patient taken any pain relieving, non-steroidal anti-inflammatory, or aspirin containing medications (*check all that apply*):

- a. Acetaminophen (Tylenol): (1)
- b. Aspirin - 325 mg: (1)
- c. Aspirin - 81 mg: (1)
- d. Celecoxib (Celebrex): (1)
- e. Ibuprofen (Advil, Motrin): (1)
- f. Indomethacin (Indocin): (1)
- g. Naproxen (Aleve, Naprosyn): (1)
- h. Valdecoxib (Bextra): (1)
- i. Other, (*specify*): (1)

j. Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. None of the above: (1)

29. Since the last visit, has the patient taken any strong opiate medications containing acetaminophen (*check all that apply*):

- a. Darvocet: (1)
- b. Esgic - Plus: (1)
- c. Fioricet: (1)
- d. Lorcet: (1)
- e. Lortab: (1)
- f. Norco: (1)
- g. Percocet: (1)
- h. Talacen: (1)
- i. Tylenol #3: (1)
- j. Tylenol #4: (1)
- k. Tylox: (1)
- l. Vicodin: ()
- m. Wygesic: (1)
- n. Other, (*specify*): (1)

o. None of the above ()

30. Since the last visit, has the patient taken any histamine H2 receptor antagonists or other gastrointestinal medications (*check all that apply*):

- a.** Cimetidine (Tagamet): (1)
- b.** Esomeprazole magnesium (Nexium): (1)
- c.** Famotidine (Pepcid): (1)
- d.** Lansoprazole (Prevacid): (1)
- e.** Nizatidine (Axid): (1)
- f.** Omeprazole (Prilosec): (1)
- g.** Ranitidine (Zantac): (1)
- h.** Ranitidine bismuth citrate (Tritec): (1)
- i.** Antacids, (*specify*): (1)

j. Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. None of the above: (1)

31. Since the last visit, has the patient taken any anticoagulant or antiplatelet medications (*check all that apply*):

- a.** Clopidogrel (Plavix): (1)
- b.** Dipyridamole: (1)
- c.** Heparin: (1)
- d.** Ticlopidine (Ticlid): (1)
- e.** Warfarin (Coumadin): (1)
- f.** Other, (*specify*): (1)

g. Other, (*specify*): (1)

h. None of the above: (1)

32. Since the last visit, has the patient taken any systemic corticosteroids (*check all that apply*):

- a.** Betamethasone sodium (Celestone): (1)
- b.** Cortisol: (1)
- c.** Cortisone: (1)
- d.** Dexamethasone (Decadron): (1)
- e.** Hydrocortisone (Hydrocortone): (1)
- f.** Methylprednisolone (Solu-Medrol): (1)
- g.** Prednisolone (Prelone): (1)
- h.** Prednisone: (1)
- i.** Triamcinolone (Acetocort, Amcort, Aristocort, Kenacort): (1)
- j.** Other, (*specify*): (1)

k. Other, (*specify*): (1)

l. None of the above: (1)

33. Since the last visit, has the patient taken any cardiovascular or antihypertensive medications (*check all that apply*):

- a.** Amiodarone (Pacerone): (1)
- b.** Amlodipine besylate (Norvasc): (1)
- c.** Atenolol (Tenormin): (1)
- d.** Benazepril (Lotensin): (1)
- e.** Captopril (Capoten): (1)
- f.** Clonidine (Catapres): (1)
- g.** Digoxin (Lanoxin): (1)
- h.** Diltiazem (Cardizem): (1)
- i.** Doxazosin (Cardura): (1)
- j.** Enalapril (Vasotec): (1)
- k.** Felodipine (Plendil): (1)
- l.** Furosemide (Lasix): (1)
- m.** Hydrochlorothiazide (Esidrix, HydroDIURIL): (1)
- n.** Hydrochlorothiazide + triamterene (Dyazide): (1)
- o.** Lisinopril (Prinivil, Zestril): (1)
- p.** Losartan potassium (Cozaar): (1)
- q.** Losartan potassium with hydrochlorothiazide (Hyzaar): (1)
- r.** Metoprolol (Lopressor): (1)
- s.** Nifedipine (Adalat, Procardia): (1)
- t.** Perhexiline maleate: (1)
- u.** Propranolol (Inderal): (1)
- v.** Quinapril (Accupril): (1)
- w.** Terazosin (Hytrin): (1)
- x.** Timolol maleate (Blocadren): (1)
- y.** Valsartan (Diovan): (1)
- z.** Verapamil (Calan): (1)
- aa.** Other, (*specify*): (1)

ab. Other, (*specify*): (1)

ac. None of the above: (1)

34. Since the last visit, has the patient taken any estrogen, progestin, anabolic steroids, hormone replacement therapy, or selective estrogen receptor modulators (*check all that apply*):

- a.** Conjugated estrogen (Premarin/Prempro): (1)
- b.** Diethylstilbestrol and methyltestosterone (Tylosterone): (1)
- c.** Esterified estrogen (Estratab, Menest): (1)
- d.** Estradiol (Estrace): (1)
- e.** Ethinyl estradiol (Estinyl): (1)
- f.** Fluoxymesterone (Android-F, Halotestin): (1)
- g.** Levonorgestrel (Norplant): (1)
- h.** Medroxyprogesterone (Cycrin, Provera): (1)
- i.** Megestrol (Megace): (1)
- j.** Methyltestosterone (Android): (1)
- k.** Nandrolone (Deca-Durabolin, Hybolin Decanoate, Kabolin): (1)
- l.** Norethindrone (Micronor): (1)
- m.** Norgestrel (Ovrette): (1)
- n.** Oral contraceptives (Alesse, Demulen, Desogen, Estrostep, Genora, Intercon, Levlen, Levlite, Levora, Loestrin, Lo-Ovral, Necon, Nelova, Nordette, Norethin, Norinyl, Ortho Cyclen, Ortho-Novum, Ortho Tri-Cyclen, Ovral, Tri-Levlen, Triphasil, Trivora, Zovia): (1)
- o.** Oxandrolone (Oxandrin): (1)
- p.** Oxymetholone (Anadrol): (1)
- q.** Progesterone (Prometrium): (1)
- r.** Raloxifene (Evista): (1)
- s.** Tamoxifen (Nolvadex): (1)
- t.** Other, (*specify*): (1)

u. Other, (*specify*): (1)

v. None of the above: (1)

35. Since the last visit, has the patient taken any allergy or asthma medications (*check all that apply*):

- a. Albuterol: (1)
- b. Beclomethasone dipropionate (Beclovent, Vanceril): (1)
- c. Budesonide (Pulmicort, Rhinocort): (1)
- d. Fluticasone propionate (Flonase, Flovent): (1)
- e. Loratadine (Claritin): (1)
- f. Mometasone furoate (Nasonex): (1)
- g. Triamcinolone acetonide (Azmacort, Nasacort): (1)
- h. Other, (*specify*): (1)
-
- i. Other, (*specify*): (1)
-
- j. None of the above: (1)

36. Since the last visit, has the patient taken a multivitamin regularly:

(Yes 1) (No 2)

37. Since the last visit, has the patient taken vitamins other than multivitamins (*do not include PIVENS study medication*):

(Yes 1) (No 2)

40. —

38. Which vitamins has the patient taken (*check all that apply*):

- a. Vitamin B (any type): (1)
- b. Vitamin C: (1)
- c. Vitamin D: (1)
- d. Vitamin E (alpha-tocopherol): (1)
- e. Other, (*specify*): (1)
-

39. Is the patient currently taking vitamin E at a dose greater than 100 IU/day (*do not include PIVENS study medication*):

(Yes * 1) (No 2)

**Remind patient not to take vitamin E supplements at doses greater than 100 IU/day during PIVENS.*

40. Since the last visit, has the patient taken any supplements (*check all that apply*):

- a. Alpha-lipoic acid: (1)
- b. Beta-carotene: (1)
- c. Betaine (Cystadane): (1)
- d. Calcium (any form): (1)
- e. Carnitine (any form): (1)
- f. Chondroitin (any form): (1)
- g. Choline + methionine + betaine + adenosine + pyridoxine (Epocler): (1)
- h. Cod liver oil: (1)
- i. Coenzyme Q: (1)
- j. Dichloroacetate: (1)
- k. Echinacea: (1)
- l. Fish oil (any form): (1)
- m. Flax seed oil: (1)
- n. Garlic: (1)
- o. Ginkgo biloba: (1)
- p. Glucosamine (any form): (1)
- q. Lecithin: (1)
- r. Magnesium: (1)
- s. Milk thistle: (1)
- t. N-acetyl-cysteine: (1)
- u. Potassium (any form): (1)
- v. Probiotics (any form): (1)
- w. S-adenylmethionine (SAM-e): (1)
- x. Saw palmetto: (1)
- y. Selenium: (1)
- z. St. John's Wort: (1)
- aa. Taurine: (1)
- ab. Zinc picolinate: (1)
- ac. Other, (*specify*): (1)
-
- ad. Other, (*specify*): (1)
-
- ae. None of the above: (1)

41. Since the last visit, has the patient taken any of the following medications or other supplements or medications (*record all other supplements or medications*):

- | | |
|---|-------|
| a. Demeclocycline (Declomycin): | (1) |
| b. Divalproex (Depakote): | (1) |
| c. Doxycycline (Monodox): | (1) |
| d. Isotretinoin (Accutane): | (1) |
| e. Levothyroxine (Levoxyl, Synthroid): | (1) |
| f. Liothyronine (Cytomel): | (1) |
| g. Methotrexate (Rheumatrex): | (1) |
| h. Minocycline (Dynacin, Minocin): | (1) |
| i. Oxytetracycline (Terramycin): | (1) |
| j. Penicillamine (Cuprimine, Depen): | (1) |
| k. Tetracycline (Achromycin): | (1) |
| l. Trientine hydrochloride (Syprine): | (1) |
| m. Ursodeoxycholic acid (Actigall, Urso,
Ursodiol): | (1) |
| n. Valproate sodium (Depacon): | (1) |
| o. Valproic acid (Depakene): | (1) |
| p. Other, (<i>specify</i>): | (1) |

q. Other, (specify): _____ ()

r. Other, (specify): _____ ()

s. Other, (specify): _____ ()

t. Other, (specify): _____ ()

u. None of the above: ()

H. Administrative information

42. Study Physician PIN: _____

43. Study Physician signature:

44. Clinical Coordinator PIN: _____

45. Clinical Coordinator signature:

46. Date form reviewed:

_____ day _____ mon _____ year

PIVENS

LQ – Symptoms of Liver Disease

Purpose: To obtain the patient's view of his/her liver disease symptoms.

When: Visits s2, f048, f096, and f120.

Administered by: Self-administered during the visit, but Clinical Coordinator must be available to answer questions and review the form for completeness.

Respondent: Patient.

Instructions: The Clinical Coordinator should complete Part A below and attach a label to each of pages 2-4. The patient should complete pages 2-4 during the visit. The Clinical Coordinator should review the completed form for missing responses and resolve any problems before the patient leaves the clinical center. Page 1 should be reattached to pages 2-4 and the Clinical Coordinator should then complete section B below.

A. Center, patient, and visit identification

1. Center ID: _____
2. Patient ID: _____
3. Patient code: _____
4. Date of visit: _____
 _____ day _____ mon _____ year
5. Visit code: _____
6. Form & revision: 1 q 1
7. Study: PIVENS 2

B. Administrative information

(To be completed by Clinical Coordinator after survey is completed.)

8. Clinical Coordinator
 - a. PIN: _____
 - b. Signature: _____
9. Date form reviewed: _____
 _____ day _____ mon _____ year

Symptoms of Liver Disease

Affix label here

Patient ID: _____

Patient code: _____

Visit code: _____

Instructions: People with liver disease may or may not have symptoms, such as pain over the liver area (right upper quadrant), nausea, poor appetite, itching, tiredness, or fatigue. In this questionnaire, we are trying to identify what symptoms you have, how severe they are, and how much they affect your life style.

(Items 1-9 are reserved for clinical center use.)

10. During the last month, how much have you been bothered by the following:

Circle one for each symptom

	Degree of bother				
	None at all	A little bit	Moderately	Quite a bit	Extremely
a. Pain over liver (right upper quadrant)	1	2	3	4	5
b. Nausea	1	2	3	4	5
c. Poor appetite	1	2	3	4	5
d. Fatigue	1	2	3	4	5
e. Weight loss	1	2	3	4	5
f. Diarrhea	1	2	3	4	5
g. Muscle aches or cramps	1	2	3	4	5
h. Muscle weakness	1	2	3	4	5
i. Headaches	1	2	3	4	5
j. Easy bruising	1	2	3	4	5
k. Itching	1	2	3	4	5
l. Irritability	1	2	3	4	5
m. Depression/sadness	1	2	3	4	5
n. Trouble sleeping	1	2	3	4	5
o. Trouble concentrating	1	2	3	4	5
p. Jaundice (yellow color to skin, eyes, etc)	1	2	3	4	5
q. Dark urine	1	2	3	4	5
r. Swelling of ankles	1	2	3	4	5
s. Swelling of abdomen	1	2	3	4	5

Affix label here	
Patient ID:	_____
Patient code:	_____
Visit code:	_____

11. Which of the following best describes your level of fatigue and the effects of your fatigue (*choose only one*):

Circle one

- I feel completely normal and have no fatigue (**circle "1" and go to item # 16**) 1
- I have some fatigue, but I can do what I want to do without difficulty 2
- I have fatigue, and I do what I want to do but with difficulty 3
- I have fatigue and it keeps me from doing what I want to do 4
- I have fatigue that prevents me from working 5
- I have fatigue that prevents me from working and requires that I have assistance to carry out normal activities of living 6
- I am worse off than any of these statements suggest 7

12. How frequently are you bothered by fatigue (*choose only one*):

- All day, every day 1
- Part of the day, every day 2
- At least part of several days a week 3
- At least part of one day a week 4
- Less frequently 5

13. Is your fatigue typically present (*choose only one*):

- When you wake up in the morning 1
- Or does it come on with the day 2
- Or does it have no time pattern 3

14. Is your fatigue typically worse the day after a period of extra activity or exercise:

- Yes 1
- No 2

<i>Affix label here</i>	
Patient ID:	____
Patient code:	____
Visit code:	____

15. Do you believe that your fatigue is due to your liver problem (as opposed to something else, like not getting enough sleep, depression or being out of shape):

Circle one

Yes	1
No	2

16. In general, how have you felt overall in the past month:

Very good	1
Good	2
Fair	3
Poor	4
Awful	5

17. Today's date:

Thank you for completing this questionnaire.

Symptoms of Liver Disease

Affix label here

Patient ID: _____

Patient code: _____

Visit code: _____

Instructions: People with liver disease may or may not have symptoms, such as pain over the liver area (right upper quadrant), nausea, poor appetite, itching, tiredness, or fatigue. In this questionnaire, we are trying to identify what symptoms you have, how severe they are, and how much they affect your life style.

(Items 1-9 are reserved for clinical center use.)

10. During the last month, how much have you been bothered by the following:

Circle one for each symptom

	Degree of bother				
	None at all	A little bit	Moderately	Quite a bit	Extremely
a. Pain over liver (right upper quadrant)	1	2	3	4	5
b. Nausea	1	2	3	4	5
c. Poor appetite	1	2	3	4	5
d. Fatigue	1	2	3	4	5
e. Weight loss	1	2	3	4	5
f. Diarrhea	1	2	3	4	5
g. Muscle aches or cramps	1	2	3	4	5
h. Muscle weakness	1	2	3	4	5
i. Headaches	1	2	3	4	5
j. Easy bruising	1	2	3	4	5
k. Itching	1	2	3	4	5
l. Irritability	1	2	3	4	5
m. Depression/sadness	1	2	3	4	5
n. Trouble sleeping	1	2	3	4	5
o. Trouble concentrating	1	2	3	4	5
p. Jaundice (yellow color to skin, eyes, etc)	1	2	3	4	5
q. Dark urine	1	2	3	4	5
r. Swelling of ankles	1	2	3	4	5
s. Swelling of abdomen	1	2	3	4	5

Affix label here	
Patient ID:	_____
Patient code:	_____
Visit code:	_____

11. Which of the following best describes your level of fatigue and the effects of your fatigue (*choose only one*):

Circle one

- I feel completely normal and have no fatigue (**circle "1" and go to item # 16**) 1
- I have some fatigue, but I can do what I want to do without difficulty 2
- I have fatigue, and I do what I want to do but with difficulty 3
- I have fatigue and it keeps me from doing what I want to do 4
- I have fatigue that prevents me from working 5
- I have fatigue that prevents me from working and requires that I have assistance to carry out normal activities of living 6
- I am worse off than any of these statements suggest 7

12. How frequently are you bothered by fatigue (*choose only one*):

- All day, every day 1
- Part of the day, every day 2
- At least part of several days a week 3
- At least part of one day a week 4
- Less frequently 5

13. Is your fatigue typically present (*choose only one*):

- When you wake up in the morning 1
- Or does it come on with the day 2
- Or does it have no time pattern 3

14. Is your fatigue typically worse the day after a period of extra activity or exercise:

- Yes 1
- No 2

<i>Affix label here</i>	
Patient ID:	____
Patient code:	____
Visit code:	____

15. Do you believe that your fatigue is due to your liver problem (as opposed to something else, like not getting enough sleep, depression or being out of shape):

Circle one

Yes	1
No	2

16. In general, how have you felt overall in the past month:

Very good	1
Good	2
Fair	3
Poor	4
Awful	5

17. Today's date:

Thank you for completing this questionnaire.

PIVENS

LR - Laboratory Results - Tests Done at s1 and During Followup

Purpose: To record archival and current laboratory test results for tests done during both screening and followup.

When: Visits s1, f002, f004, f008, f012, f016, f024, f032, f040, f048, f056, f064, f072, f080, f088, f096, and f120.

Administered by: Study Physician and Clinical Coordinator.

Instructions: Laboratory test results may be obtained from chart review. Complete tests as needed (repeat tests if archival test is not within the required time window). The window for each test is specified next to the date of blood draw. Use a calculator if you need to convert units to match the units specified on this form. Call the DCC if you have any questions about conversions or how to record a value. If ☒ is checked in item 59, the patient is not eligible for PIVENS and the form should not be keyed. Attach copies of the laboratory reports to this form.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit:
 _____ day _____ mon _____ year

5. Visit code: _____

6. Form & revision: 1 r 1

7. Study: PIVENS 2

B. Hematology

Required at visits s1, f024, f048, f096, and f120.

8. Is hematology testing required at this visit:

(^{Yes}
1) (^{No}
2)
☒ 14.

9. Date of blood draw for complete blood count:

_____ day _____ mon _____ year

Date must be within the required time window; within 3 months of screening or in the time window for the followup visit (check the patient's PIVENS visit time window guide).

10. Hemoglobin: _____ g/dL

11. Hematocrit: _____ %

12. White blood cell count (WBC):

_____ •
 10³ cells/μL or 10⁹ cells/L

13. Platelet count:

_____ , _____
 cells/μL

C. Chemistries

Required at visits s1, f024, f048, and f096.

14. Is metabolic panel required at this visit:

(^{Yes}
1) (^{No}
2)
☒ 27.

15. Date of blood draw for chemistries:

_____ day _____ mon _____ year

Date must be within the required time window; within 3 months of screening or in the time window for the followup visit (check the patient's PIVENS visit time window guide).

16. Sodium: _____ mEq/L

17. Potassium: _____ mEq/L

18. Chloride: _____ mEq/L

19. Bicarbonate: _____ mEq/L

20. Calcium: _____ mg/dL

21. Phosphate: _____ mg/dL

22. Blood urea nitrogen (BUN): _____ mg/dL

23. Creatinine (if serum creatinine ≥ 2.0 mg/dL, patient is ineligible):

_____ • _____
mg/dL

24. Uric acid:

_____ • _____
mg/dL

25. Albumin (if albumin < 3.0 g/dL and physician judges patient has cirrhosis, patient is ineligible):

_____ • _____
g/dL

26. Total protein:

_____ • _____
g/dL

D. Prothrombin time, GGT, and HbA1c

Required at visits f048 and f096.

27. Are the prothrombin time, GGT, and HbA1c tests required at this visit:

(Yes) (No)
(1) (2)
33. _____

28. Date of blood draw for prothrombin time, GGT, and HbA1c:

_____ day _____ mon _____ year

Date must be in the time window for the followup visit (check the patient's PIVENS visit time window guide).

29. Prothrombin time (PT):

_____ • _____
sec

30. International normalized ratio (INR):

_____ • _____

31. Gamma glutamyl transferase (GGT):

_____ U/L

32. HbA1c:

_____ • _____
%

E. Liver panel

Required at visits f002, f004, f008, f012, f016, f024, f032, f040, f048, f056, f064, f072, f080, f088, f096, and f120.

33. Is hepatic panel required at this visit:

(Yes) (No)
(1) (2)
40. _____

34. Date of blood draw for liver panel:

_____ day _____ mon _____ year

Date must be in the time window for the followup visit (check the patient's PIVENS visit time window guide).

35. Bilirubin (total):

_____ • _____
mg/dL

36. Bilirubin (conjugated or direct):

_____ • _____
mg/dL

37. Aspartate aminotransferase (AST)

_____ U/L

- a. Upper limit of normal:

_____ U/L

- b. Lower limit of normal:

_____ U/L

38. Alanine aminotransferase (ALT)

_____ U/L

- a. Upper limit of normal:

_____ U/L

- b. Lower limit of normal:

_____ U/L

39. Alkaline phosphatase

_____ U/L

- a. Upper limit of normal:

_____ U/L

- b. Lower limit of normal:

_____ U/L

F. Fasting lipid profile

Required at visits s1, f048, f096, and f120.

Fasting is defined as nothing by mouth except water for greater than or equal to 12 hours prior to blood draw.

40. Is fasting lipid profile required at this visit:

Yes (1) No (2)
42. —

41. Date of blood draw for fasting lipid profile:

— day — mon — year

Date must be within the required time window; within 3 months of screening or in the time window for the followup visit (check the patient's PIVENS visit time window guide).

- a. Triglycerides: — mg/dL
- b. Total cholesterol: — mg/dL
- c. HDL cholesterol level: — mg/dL
- d. LDL cholesterol level: — mg/dL

G. Fasting glucose

Required at visits s1, f024, and f072. Also required at visits f048, f096, and f120 if the patient is diabetic.

Fasting is defined as nothing by mouth except water for at least 12 hours prior to blood draw.

42. Is fasting glucose required at this visit:

Yes (1) No (2)
45. —

43. Date of blood draw for fasting glucose level:

— day — mon — year

Date must be within the required time window; within 3 months of screening or in the time window for the followup visit (check the patient's PIVENS visit time window guide).

44. Serum glucose (if fasting glucose ≥ 126 mg/dL, patient is ineligible):

— mg/dL

H. Oral glucose tolerance test

Required at visits f048, f096, and f120.

The oral glucose tolerance test will be performed in the morning after a 12-hour overnight fasting. Baseline blood sample will be obtained for measurements of serum glucose, insulin, and C peptide. Subsequent blood samples will be obtained every 30 minutes for 120 minutes for the measurement of serum glucose and insulin after oral administration of flavored glucose solution in a dose of 75 g.

45. Is oral glucose tolerance test (OGTT) required at this visit:

Yes (1)
No (2)
No, patient is diabetic (3)
52. —
52. —

46. Date of blood draw for OGTT:

— day — mon — year

Date must be in the time window for the followup visit (check the patient's PIVENS visit time window guide).

47. OGTT results at baseline

- a. Serum glucose: — mg/dL
- b. Serum insulin: — μ U/mL •
- c. Serum C peptide: — ng/mL •

48. OGTT results at 30 minutes

- a. Serum glucose: — mg/dL
- b. Serum insulin: — μ U/mL •

49. OGTT results at 1 hour

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

50. OGTT results at 90 minutes

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

51. OGTT results at 2 hours

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

I. Microalbuminuria

Required at visits f048, f096, and f120.

52. Is microalbuminuria required at this visit:

Yes (1) No (2)
☒ 55.

53. Date of urine collection for dipstick:

_____ day _____ mon _____ year

Date must be in the time window for the followup visit (check the patient's PIVENS visit time window guide).

54. Microalbuminuria:

Positive (1)
 Negative (2)

J. Pregnancy test

Required at all study visits if applicable.

55. Is pregnancy test applicable:

Yes (1) No (2)
☒ 58.

56. Date of urine collection (or blood draw):

_____ day _____ mon _____ year

Date must be the same day as date of visit.

57. Pregnancy test result (if pregnancy test is positive at s1, patient is ineligible):

Positive (1)
 Negative (2)

K. Eligibility check**58. Is this the s1 visit:**

Yes (1) No (2)
☒ 60.

59. Was the patient found to be ineligible based on creatinine (item 23), albumin (item 25), serum glucose (item 44), or pregnancy test (item 57):

Yes (1) No (2)
☒ 60.

L. Administrative information

60. Study Physician PIN: _____

61. Study Physician signature: _____

62. Clinical Coordinator PIN: _____

63. Clinical Coordinator signature: _____

64. Date form reviewed:

_____ day _____ mon _____ year

LS - Laboratory Results
Tests Done Only During Screening

Purpose: To record archival and current results of laboratory tests done only at screening.

When: Visit s1.

Administered by: Study Physician and Clinical Coordinator.

Instructions: Laboratory test may be obtained from chart review. The acceptable time interval for archival laboratory data is specified for each test and recorded next to the date of blood draw. Laboratory tests should be repeated if the blood draw date is outside the specified time interval. If  is checked for any item the patient is not eligible for the PIVENS trial. If  is checked for an item, use caution. If the Study Physician agrees with the diagnosis, the patient is ineligible for PIVENS.

A. Center, patient, and visit identification

1. Center ID: _____
2. Patient ID: _____
3. Patient code: _____
4. Date of visit: _____
_____ day _____ mon _____ year
5. Visit code: _____ s _____ 1 _____
6. Form & revision: _____ 1 _____ s _____ 1 _____
7. Study: PIVENS 2

B. Screening etiologic tests

8. Date of blood draw for serological assays
to exclude viral causes of chronic liver
disease:
- _____ day _____ mon _____ year
- Repeat if date is greater than 1 year prior to
screening.*
- a. Hepatitis B surface antigen (HBsAg):**
- Positive (1)
- Negative (2)
- b. Hepatitis B core total antibody
(anti-HBc) (if total anti-HBc is not available,
record results from IgG test):**
- Positive (1)
- Negative (2)
- Not available (3)
- c. Hepatitis B surface antibody
(anti-HBs):**
- Positive (1)
- Negative (2)
- Not available (3)
- d. Hepatitis C antibody (anti-HCV) (indicate re-
sult as negative if EIA is positive but RIBA is
negative):**
- Positive (1)
- Negative (2)
- e. Hepatitis C virus RNA (HCV RNA):**
- Positive (1)
- Negative (2)
- Not available (3)

C. Autoantibody studies

9. Date of blood draw for autoantibody studies:

_____ day _____ mon _____ year

Repeat if date is greater than 5 years prior to screening.

10. Antinuclear antibody (ANA):

Positive (* 1)

Negative (2)

12. _____

- a. If positive, ANA: 1/ _____

** If results are given as units, record as "n" and key the actual result in the General Comments.*

11. Is ANA titration greater than 1:80

Yes (* 1) No (2)


** Check Liver Biopsy Histology Findings Form for autoimmune liver disease.*

12. Antimitochondrial antibody (AMA):

Positive (* 1)

Negative (2)

14. _____

- a. If positive, AMA: 1/ _____

** If results are given as units, record as "n" and key the actual result in the General Comments.*

13. Is AMA titration greater than 1:80

Yes (* 1) No (2)


** Check Liver Biopsy Histology Findings Form for primary biliary cirrhosis.*

14. Antismooth muscle antibody (ASMA):

Positive (* 1)

Negative (2)

15. _____

- a. If positive, ASMA: 1/ _____

** If results are given as units, record as "n" and key the actual result in the General Comments.*

D. Ceruloplasmin

15. Is patient 40 years old or younger:

Yes (1) No (2)

18. _____

16. Date of blood draw for ceruloplasmin:
(required only if patient is 40 years old or younger):

_____ day _____ mon _____ year

Repeat if date is greater than 10 years prior to screening.

17. Ceruloplasmin

_____ mg/dL

a. Lower limit of normal: _____ mg/dL

- b. Is ceruloplasmin below the lower limit of normal:

Yes (* 1) No (2)


** Check Liver Biopsy Histology Findings Form for Wilson's Disease.*

E. Alpha-1 antitrypsin

18. Date of blood draw for alpha-1 antitrypsin (A1AT):

_____ day _____ mon _____ year

Repeat if date is greater than 10 years prior to screening.

19. Alpha-1 antitrypsin (A1AT)

_____ mg/dL

a. Lower limit of normal: _____ mg/dL

- b. Is A1AT below the lower limit of normal:

Yes (* 1) No (2)


** Check Liver Biopsy Histology Findings Form for A1AT deficiency.*

F. Iron

20. Date of blood draw for iron overload screening:

____ day ____ mon ____ year

Repeat if date is greater than 5 years prior to screening.

a. Iron: _____
μg/dL

b. Total Iron Binding Capacity: _____
μg/dL

c. Ferritin: _____
ng/mL

21. Is hepatic iron index available:

(Yes) (No)
(1) (2)

23. _____

22. Hepatic iron index: _____
μmol/g/year

G. Administrative information

23. Study Physician PIN: _____

24. Study Physician signature:

25. Clinic Coordinator PIN: _____

26. Clinic Coordinator signature:

27. Date form reviewed:

____ day ____ mon ____ year

PIVENS

LU - Laboratory Results - Tests Required at Visit s2

Purpose: To record archival and current laboratory test results for tests required at visit s2.

When: Visit s2.

Administered by: Study Physician and Clinical Coordinator.

Instructions: Laboratory test results may be obtained from chart review. Complete tests as needed (repeat tests if archival test is not within the required time window). The window for each test is specified next to the date of blood draw. Use a calculator if you need to convert units to match the units specified on this form. Call the DCC if you have any questions about conversions or how to record a value. If ☒ is checked in item 29, the patient is not eligible for PIVENS and the form should not be keyed. Attach copies of the laboratory reports to this form.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit:
 _____ day _____ mon _____ year

5. Visit code: s 2 _____

6. Form & revision: 1 u 1

7. Study: PIVENS 2

B. Prothrombin time, GGT, and HbA1c

8. Date of blood draw for prothrombin time, GGT, and HbA1c:
 _____ day _____ mon _____ year
Date must be within 3 months of screening.

9. Prothrombin time (PT): _____ sec

10. International normalized ratio (INR) (*if INR > 1.3 and physician judges patient has cirrhosis, patient is ineligible*):

11. Gamma glutamyl transferase (GGT):
 _____ U/L

12. HbA1c: _____ %

C. Liver panel

13. Date of blood draw for liver panel:
 _____ day _____ mon _____ year
Date must be within within 3 months of screening.

14. Bilirubin (total): _____ mg/dL

15. Bilirubin (conjugated or direct) (*if conjugated bilirubin > 2 mg/dL and physician judges patient has cirrhosis, patient is ineligible*):
 _____ mg/dL

16. Aspartate aminotransferase (AST)
 _____ U/L

a. Upper limit of normal: _____ U/L

b. Lower limit of normal: _____ U/L

17. Alanine aminotransferase (ALT) (*if ALT > 300 U/L, patient is ineligible*)
 _____ U/L

a. Upper limit of normal: _____ U/L

b. Lower limit of normal: _____ U/L

18. Alkaline phosphatase
 _____ U/L

a. Upper limit of normal: _____ U/L

b. Lower limit of normal: _____ U/L

D. Oral glucose tolerance test

The oral glucose tolerance test will be performed in the morning after a 12-hour overnight fasting. Baseline blood sample will be obtained for measurements of serum glucose, insulin, and C peptide. Subsequent blood samples will be obtained every 30 minutes for 120 minutes for the measurement of serum glucose and insulin after oral administration of flavored glucose solution in a dose of 75 g.

19. Date of blood draw for OGTT:

_____ day _____ mon _____ year

Date must be within 3 months of screening.

20. OGTT results at baseline

a. Serum glucose (if fasting glucose ≥ 126 mg/dL, patient is ineligible):

_____ mg/dL

b. Serum insulin: _____ μ U/mL

c. Serum C peptide: _____ ng/mL

21. OGTT results at 30 minutes

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

22. OGTT results at 1 hour

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

23. OGTT results at 90 minutes

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

24. OGTT results at 2 hours

a. Serum glucose: _____ mg/dL

b. Serum insulin: _____ μ U/mL

E. Microalbuminuria**25. Date of urine collection for dipstick:**

_____ day _____ mon _____ year

Date must be within 3 months of screening.

26. Microalbuminuria:

Positive (1)

Negative (2)

F. Pregnancy test**27. Is pregnancy test applicable:**

(Yes 1) (No 2)

30.

28. Date of urine collection (or blood draw):

_____ day _____ mon _____ year

Date must be the same day as date of visit.

29. Pregnancy test results (if pregnancy test is positive, patient is ineligible):

Positive (1)

Negative (2)

G. Eligibility check

30. Was the patient found to be ineligible based on INR (item 10), conjugated (or direct) bilirubin (item 15), ALT (item 17), glucose (item 20a), or pregnancy test (item 29):

(Yes 1) (No 2)

Elig

H. Administrative information

31. Study Physician PIN: — — —

32. Study Physician signature:

33. Clinical Coordinator PIN: — — —

34. Clinical Coordinator signature:

35. Date form reviewed:
 — — — —
 day mon year

PIVENS**PA – Physical Activity**

Purpose: To obtain the patient's physical activity.

When: Visits s2, f048, f096, and f120.

Administered by: Self-administered, but Clinical Coordinator must be available at visits to answer questions and review the completed form.

Respondent: Patient, without help from spouse or family.

Instructions: The Clinical Coordinator should complete section A below and attach a label to each of pages 2-4.

Screening: The patient should meet with the Clinical Coordinator, be trained in completion of the form, and then should complete pages 2-4. The Clinical Coordinator should review the completed form for missing responses and resolve any problems before the patient leaves the clinical center. Page 1 should be reattached to pages 2-4 and the Clinical Coordinator should complete section B below. **Followup:** Pages 2-4 may be mailed to the patient 2 weeks prior to the scheduled study visit with instructions to complete the form at home and to bring the completed form to the next study visit. When the patient returns for the visit, the Clinical Coordinator should review the form for completeness and obtain responses for missing items during the visit. If the patient did not bring a completed form to the visit, the patient should complete the form at the visit. Page 1 should be reattached to pages 2-4 and the Clinical Coordinator should complete section B. Item 4 should be completed with the date the patient wrote in item 39. If the patient did not write in a date, use the date of the study visit for the visit date.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Date of visit (*date patient completed the form*):

_____ day _____ mon _____ year

5. Visit code: _____

6. Form & revision: p a 1

7. Study: PIVENS 2

B. Administrative information

(*To be completed by Clinical Coordinator after survey is completed.*)

8. Clinical Coordinator

a. PIN: _____

b. Signature: _____

9. Date form reviewed:

_____ day _____ mon _____ year

Affix label here	
Patient ID:	_____
Patient code:	_____
Visit code:	_____

PA - Physical Activity

Instructions: This survey asks for your views about your physical activity. *(Items 1-9 are reserved for clinical center use).*

C. Non-Recreational Activity (Work Related)

The following questions are about your non-recreational activity. Non-recreational activity is what you consider your main day to day activity, at work or at home, whether you get paid or not.

Circle one

10. Level of activity that best describes your usual non-recreational activity.

Vigorous or strenuous activity: 1
(involves heavy lifting, digging, handling heavy tools or equipment, or any other activity causing you to work up a sweat or get out of breath)

Moderate activity: 2
(requires moderate-paced walking on a flat surface, heavy one-arm work or moderate two-arm work, such as picking, sweeping, lifting light objects, or heavy housework)

Light activity: 3
(involves sitting down with one hand movement, moderate one-arm work or light two-arm work, with occasional walking or standing such as office work, filing or sorting, or light or moderate housework)

11. On average, how many hours per day do you spend at this level of activity?

_____ Hours

12. On average, how many hours per day do you spend sitting down?

_____ Hours

Patient ID: _____

Patient code: _____

Visit code: _____

D. Recreational Activity (Non-Work Related)

The following questions are about the recreational activities you spend at least 15 minutes doing each week. You should count walking or biking to work and any other activities outside of work. Next to each activity that you participate in, write in how many total hours or minutes you do that activity on an average week. Mark the places for hours and minutes only for the activities you participate in.

For each activity that you engage in for at least 15 minutes per week, please circle the activity and write the number of hours or minutes that you do that activity per week.	
13. Swimming	Hours: _____ Minutes: _____
14. Jogging	Hours: _____ Minutes: _____
15. Running	Hours: _____ Minutes: _____
16. Brisk walking	Hours: _____ Minutes: _____
17. Bicycling on hills	Hours: _____ Minutes: _____
18. Bicycling on flat surfaces	Hours: _____ Minutes: _____
19. Hiking or climbing	Hours: _____ Minutes: _____
20. Yard work / Gardening	Hours: _____ Minutes: _____
21. Aerobics	Hours: _____ Minutes: _____
22. Dancing	Hours: _____ Minutes: _____
23. Calisthenics (exercises without machines)	Hours: _____ Minutes: _____
24. Weight lifting, using weight machines, or heavy lifting	Hours: _____ Minutes: _____
25. Treadmill or Stairmaster	Hours: _____ Minutes: _____
26. Chopping wood	Hours: _____ Minutes: _____

Affix label here

Patient ID: _____

Patient code: _____

Visit code: _____

For each activity that you engage in for at least 15 minutes per week, please circle the activity and write the number of hours or minutes that you do that activity per week.

27. Painting / Woodworking	Hours: _____ Minutes: _____
28. Housecleaning	Hours: _____ Minutes: _____
29. Golfing	Hours: _____ Minutes: _____
30. Singles tennis, racquetball, or other court sports	Hours: _____ Minutes: _____
31. Doubles tennis, racquetball or other court sports	Hours: _____ Minutes: _____
32. Basketball	Hours: _____ Minutes: _____
33. Football, soccer, or other field sports	Hours: _____ Minutes: _____
34. Skiing	Hours: _____ Minutes: _____
35. Bowling	Hours: _____ Minutes: _____
Others (<i>write in the name of activity</i>):	
36. Name of activity _____	Hours: _____ Minutes: _____
37. Name of activity _____	Hours: _____ Minutes: _____
38. Name of activity _____	Hours: _____ Minutes: _____

39. Today's date:

Thank you for completing this survey. Please bring this completed survey with you to your scheduled PIVENS study visit.

11. Hip (*standing, at fullest part of the hips; repeat hip measurements until you have two measurements within 4 in (10.2 cm) of each other*)

a. Circumference, 1st measurement:

_____ • _____
hip circumference

b. Circumference, 2nd measurement:

_____ • _____
hip circumference

c. Units:

Inches (1)

Centimeters (2)

12. Triceps (*right arm, with elbow extended and arm relaxed; repeat skin fold measurements until you have two within 10 mm of each other; repeat mid-upper arm circumference until you have two within 1.5 in (3.8 cm) of each other*)

a. Skin fold, 1st measurement:

_____ • _____
mm

b. Skin fold, 2nd measurement:

_____ • _____
mm

c. Mid-upper arm circumference, 1st measurement:

_____ • _____
arm circumference

d. Mid-upper arm circumference, 2nd measurement:

_____ • _____
arm circumference

e. Units for arm circumference:

Inches (1)

Centimeters (2)

13. Temperature (*oral*)

a. Degrees: _____ • _____

b. Scale:

Fahrenheit (1)

Centigrade (2)

14. Blood pressure

a. Systolic: _____
mmHg

b. Diastolic: _____
mmHg

15. Resting radial pulse: _____
beats/minute

16. Respiratory rate: _____
breaths/minute

C. Examination findings

17. Skin:

Normal (1)

Abnormal (2)

20.

18. Acanthosis nigricans (*check only one*):

Absent (*not detectable on close inspection*) (0)

Present (*clearly present on close inspection, not visible to casual observer, extent not measurable*) (1)

Mild (*limited to base of skull, not extending to lateral margins of neck, < 3 inches in breadth*) (2)

Moderate (*extending to lateral margins of neck, 3-6 inches in breadth, not visible from patient's front*) (3)

Severe (*extending anteriorly, > 6 inches in breadth, visible from front*) (4)

19. Other skin abnormality (*check all that apply*)

a. Jaundice: (1)

b. Palmar erythema: (1)

c. Spider angiomas: (1)

d. Other (*specify*): (1)

e. None of the above: (1)

20. Head, eyes, ears, nose, throat:

Normal (1)

Abnormal (2)

22.

21. Abnormality of the head, eyes, nose, throat (*check all that apply*)

a. Jaundice: (1)

b. Other (*specify*): (1)

specify

22. Neck:

Normal (1)
 Abnormal **23.** (2)

 specify abnormality

23. Lymphatic:

Normal (1)
 Abnormal **24.** (2)

 specify abnormality

24. Chest and lungs:

Normal (1)
 Abnormal **25.** (2)

 specify abnormality

25. Heart:

Normal (1)
 Abnormal **26.** (2)

 specify abnormality

26. Abdomen:

Normal (1)
 Abnormal **28.** (2)

**27. Abdomen abnormality
(check all that apply)**

a. Ascites: (1)
b. Obese: (1)
c. Other (specify): (1)

 specify abnormality

28. Liver and spleen:

Normal (1)
 Abnormal **30.** (2)

29. Abnormality of liver or spleen (check all that apply)

a. Hepatomegaly: (1)
 (if checked, span from right midclavicular line):

_____ • _____
 cm

b. Splenomegaly: (1)

c. Other (specify): (1)

 specify abnormality

30. Extremities:

Not performed (0)

Normal **32.** (1)

Abnormal **32.** (2)

**31. Abnormality of the extremities
(check all that apply)**

a. Contractures: (1)

b. Muscle wasting: (1)

c. Palmar erythema: (1)

d. Pedal edema: (1)

e. Other (specify): (1)

 specify abnormality

32. Genitourinary/pelvis:

Not performed (0)

Normal **33.** (1)

Abnormal **33.** (2)

 specify abnormality

33. Nervous system:

Not performed (0)
 35. Normal (1)
 35. Abnormal (2)

34. Abnormality of the nervous system
(check all that apply)

a. Mental status abnormal: (1)
 b. Asterixis: (1)
 c. Other *(specify)*: (1)

 specify abnormality

D. Administrative information

35. Study Physician PIN: ____

36. Study Physician signature:

37. Clinical Coordinator PIN: ____

38. Clinical Coordinator signature:

39. Date form reviewed:
 ____ day ____ mon ____ year

PIVENS

PF - Focused Physical Examination

Purpose: Record focused physical exam findings.

When: Visits f004, f008, f016, f032, f064, f072, f080, and f120.

Administered by: Study Physician and Clinical Coordinator.

Respondent: Patient.

Instructions: Details of the protocol for height, weight, waist and hip measurement are found in the PIVENS SOP Part I. In brief: height, weight, waist and hips should be measured with the patient standing and wearing light clothing. Shoes should be removed for height and weight measures. Measure the waist around the abdomen horizontally at the midpoint between the highest point of the iliac crest and the lowest part of the costal margin in the mid axillary line. Repeat waist measurements until you have two measurements within 4 in (10.2 cm) of each other. Measure the hips at the fullest part. Repeat hip measurements until you have two measurements within 4 in (10.2 cm) of each other.

A. Center, patient, and visit identification

1. Center ID: _____

2. Patient ID:

3. Patient code: _____

4. Visit date: _____
 _____ day _____ mon _____ year

5. Visit code: _____

6. Form & revision: D f 1

7. Study: PIVENS 2

B. Measurements

8. Height (*shoes off*)

a. 1st measurement:

b. 2nd measurement:

c. Units:

Inches	(1)
Centimeters	(2)

9. Weight (shoes off)

a. 1st measurement:

b. 2nd measurement:

c. Units:

Pounds	(1)
Kilograms	(2)

10. Waist (standing, at midpoint between highest point of iliac crest and lowest part of costal margin; repeat waist measurements until you have two within 4 in (10.2 cm) of each other)

a. 1st measurement:

b. 2nd measurement:

c. Units:

Inches	(<u>1</u>)
Centimeters	(<u>2</u>)

11. Hip (standing, at fullest part of the hips; repeat hip measurements until you have two within 4 in (10.2 cm) of each other)

a. 1st measurement:

b. 2nd measurement:

c. Units:

Inches	(1)
Centimeters	(2)

12. Temperature (*oral*)

a. Degrees: _____ • _____

b. Scale:

Fahrenheit: (1)

Centigrade: (2)

13. Blood pressure

a. Systolic: _____ mmHg

b. Diastolic: _____ mmHg

14. Resting radial pulse: _____ beats/minute

15. Respiratory rate: _____ breaths/minute

C. Liver signs**16. Liver and spleen:**

Normal (1)

Abnormal **18.** (2)**17. Abnormality (*check all that apply*)**

a. Ascites: (1)

b. Asterixis: (1)

c. Contractures: (1)

d. Hepatomegaly: (1)

*If Yes, span from right midclavicular line:*_____ • _____
cm

e. Jaundice: (1)

f. Muscle wasting: (1)

g. Palmar erythema: (1)

h. Pedal edema: (1)

i. Spider angiomas: (1)

j. Splenomegaly: (1)

k. Other, (*specify*): (1)_____
specify abnormality**D. Administrative information**

18. Study Physician ID: _____

19. Study Physician signature: _____

20. Clinical Coordinator ID: _____

21. Clinical Coordinator signature: _____

22. Date form reviewed: _____
day mon year

PIVENS

RG - Registration

Purpose: To register patients as candidates for enrollment in PIVENS and to assign a patient ID number, if not already enrolled in a NASH CRN study. This is the first form completed for a PIVENS patient. The Registration Form must be the first form keyed, before any other PIVENS forms.

When: At first screening visit (s1).

Administered by: Clinical Coordinator.

Respondent: Patient.

Instructions: Use Flash Cards as instructed. Do not assign a patient ID and code if patient has previously been assigned an ID for a NASH CRN study.

A. Center, patient and visit identification

1. Center ID: _____

2. Patient ID: _____

3. Patient code: _____

4. Visit date: _____
 day mon year

5. Visit code: s 1 _____

6. Form & revision: r g 1

7. Study: PIVENS 2

B. Consent

8. After reviewing the existing records (e.g., liver biopsy, elevated aminotransferases, and/or history) does the study physician feel that the patient may be suitable for the study:

Yes (1) No (2)


9. Has the patient signed the PIVENS informed consent statement:

Yes (1) No (2)


10. Has the consentor or study physician signed the consent form:

Yes (1) No (2)


C. Information about patient

11. Date of birth: _____
 day month year
 Record 4-digit year for date of birth.

12. Age at last birthday: _____
 years

13. Gender:
 Male (1)
 Female (2)

14. Ethnic category (*show the patient Flash Card #1 and ask the patient to pick the category that describes him/her best; check only one*):

Hispanic or Latino or Latina (1)
 Not Hispanic, not Latino, not Latina (2)

16. _____

15. What describes your Hispanic, Latino, or Latina origin best (*show the patient Flash Card #1 and ask the patient to pick the subcategory that best describes their Hispanic, Latino, or Latina origin; check only one*):

Mexican (1)
 Puerto Rican (2)
 Cuban (3)
 South or Central American (4)
 Other Spanish culture or origin (5)

 specify

- 16.** Racial category (*show the patient Flash Card #2 and ask the patient to pick the category or categories that describes him/her best; check all that apply*)

a. American Indian or Alaska Native: (☐ 1)
 b. Asian: (☐ 1)
 c. Black, African American, Negro, or Haitian: (☐ 1)
 d. Native Hawaiian or other Pacific Islander: (☐ 1)
 e. White: (☐ 1)
 f. Patient refused: (☐ 1)

- 17.** In what country was the patient born (*check only one*):

Continental US (includes Alaska) or Hawaii (☐ 1)
 Other, (*specify*): (☐ 2)

 specify

- 18.** Highest educational level achieved by patient (*show the patient Flash Card #3 and ask the patient to pick the category that describes him/her best; check only one*):

Never attended school (☐ 0)
 Kindergarten, pre kindergarten, or younger (☐ 1)
 Grades 1 to 5 (☐ 2)
 Grades 6-8 (☐ 3)
 Grades 9-11 (☐ 4)
 Completed high school (☐ 5)
 Some college or post high school education or training (☐ 6)
 Bachelor's degree or higher (☐ 7)

- 19.** Is the patient currently employed:

Yes (☐ 1) No (☐ 2)

22. _____

- 20.** What is the patient's current occupation:

 specify occupation

- 21.** About how many hours does the patient work each week:

 # hours

- 22.** Which of the following categories best characterizes the patient's occupational history (*show patient Flash Card #4 and ask the patient to pick the category that describes him/her best; check only one*):

Never employed (☐ 0)
 Laborer (☐ 1)
 Clerical (☐ 2)
 Professional (☐ 3)
 Homemaker (☐ 4)
 Other, (*specify*): (☐ 5)

 specify

- 23.** Marital status of the patient (*show patient Flash Card #5 and ask the patient to pick the category that describes him/her best; check only one*):

Single, never married (☐ 1)
 Married or living in marriage-like relationship (☐ 2)
 Separated, divorced, or annulled (☐ 3)
 Widowed (☐ 4)

- 24.** Combined annual income before taxes of all members of patient's household (*show patient Flash Card #6 and ask the patient to pick the category that describes his/her combined household income best; check only one*):

Less than \$15,000 (☐ 1)
 \$15,000 - \$29,999 (☐ 2)
 \$30,000 - \$49,999 (☐ 3)
 \$50,000 or more (☐ 4)

D. Source of patient

(Clinical Coordinator should pick the best description of the source of patient)

25. Source of patient (check only one):

- Bariatric surgery clinic (01)
 Current patient of NASH CRN investigator: (02)
 Diabetes clinic (03)
 GI/liver clinic (04)
 HMO-based (05)
 Internal medicine clinic (06)
 Lipid disorders clinic (07)
 Liver transplant clinic (08)
 Obesity clinic (09)
 Primary care clinic (10)
 Self referral (11)
 Other, (specify): (12)

 specify

E. Previous registration in a NASH CRN study**26. Has the patient previously been registered in a NASH CRN study:**

Yes (1) No (2)
31. _____

27. In which NASH CRN studies has the patient previously been registered (check all that apply)

- a. NAFLD Database: (1)
 b. Other, (specify): (1)

 specify

28. ID Number previously assigned to patient (record patient ID in item 2):

29. Code previously assigned to patient (record patient code in item 3):

30. Has it been at least 8 weeks since the patient was registered or enrolled in a NASH CRN study (check only one):

Registered, but not enrolled (* 0)
32. _____
 Yes (1)
32. _____
 No (* 2)
32. _____

* Use physician discretion if less than 8 weeks since previous registration or enrollment.

F. ID assignment

(If a STOP condition was checked in section B, the patient is ineligible and a Patient ID should not be assigned. If the patient was previously registered in a NASH CRN study, a new ID number should not be assigned.)

31. Place ID label below and record Patient ID in item 2 and patient code in item 3.

CCCC #####, zzz

G. Administrative information

32. Clinical Coordinator PIN: _____

33. Clinical Coordinator signature:

34. Date form reviewed:

_____ day _____ mon _____ year