Lipodystrophy Demographic and Health History Questionnaire (ART)

I. GENERAL INFORMATION

Today's Date _ _ (Month) _ _ (Day) _ _ _ _ (Year)

NAME:_____
Last First MI Maiden

ADDRESS: _____
Number Street

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER: (Home) _____
(Area Code) Number

(Work) _____
(Area Code) Number

(Cell/Pager) _____
(Area Code) Number

EMAIL ADDRESS: _____

CONTACT: May we contact you with lab/study results at the following numbers/locations including possible HIV status information?

	YES	NO	Preferred
Home	☐	☐	☐
Work	☐	☐	☐
Cell/Pager	☐	☐	☐
Email	☐	☐	☐
Mail	☐	☐	☐

BIRTHDATE: _ _ (Month) _ _ (Day) _ _ _ _ (Year)

GENDER/SEX: ☐ MALE ☐ FEMALE

ETHNIC CATEGORIES: Mark only one

- ☐ ***Hispanic*** *or* ***Latino*** (A person of Cuban, Mexican, Puerto Rican, South/Central American or other Spanish-speaking culture regardless of race)
- ☐ ***Not Hispanic*** *or* ***Latino***

RACIAL CATEGORIES: Mark all that apply

- ☐ ***Black*** *or* ***African American*** (any black African racial origins including Haitians)
- ☐ ***Asian*** (Far East, Southeast Asia or Indian Subcontinent including Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, Philippine Islands, Thailand, and Vietnam)
- ☐ ***Native Hawaiian*** *or other* ***Pacific Islander*** (any origins from Hawaii, Guam, Somoa or other Pacific Islands, specifically not the Philippine Islands)
- ☐ ***American Indian*** *or* ***Alaskan Native*** (any origins from the *original peoples* of *North*, *Central*, and *South* America)
- ☐ ***White*** (any origins from original peoples of Europe, Near/Middle East, or North Africa including Hispanics and Latino of these races)

II. PRIMARY CARE PHYSICIAN INFORMATION AND RECORDS ACCESSS

NAME OF PHYSICIAN: _____

ADDRESS: _____
Number Street

CITY: _____ STATE: _____ ZIP: _____

PHONE NUMBER OF PHYSICIAN: _____
(Area Code) Number

EMERGENCY CONTACT: _____
Name

PHONE NUMBER: _____
(Area Code) Number

III. HIV/AIDS HISTORY

HIV DIAGNOSIS DATE: _ _ _ _ _ _
(As specific as possible) Month Year

HIV RISK FACTORS: Mark all that apply (optional)

- ☐ Man who has Sex with Men (gay, homosexual, bisexual, other)
- ☐ Intravenous Drug Use (recreational IV drugs)
- ☐ Healthcare Worker Exposed at Work
- ☐ Blood or Blood Product Exposure (hemophiliacs, transfusions, etc..)
- ☐ Exchanged Money or Drugs for Sex (prostitute or sex with prostitute)
- ☐ Only Heterosexual Exposure
- ☐ *none of the Above*

MOST RECENT CD4+ T-Cell COUNT: _____
(As specific as possible) # / mm^3

DATE: _ _ _ _ _ _
Month Year

LOWEST CD4+ T-Cell COUNT: _____
(As specific as possible) # / mm^3

DATE: _ _ _ _ _ _
Month Year

MOST RECENT VIRAL LOAD: _____
(As specific as possible) cp / mm^3

DATE: _ _ _ _ _ _
Month Year

HIGHEST VIRAL LOAD: _____
(As specific as possible) cp / mm^3

DATE: _ _ _ _ _ _
Month Year

Anti-HIV MEDICATIONS: Have you taken any medication to treat your HIV infection?

☐ No ☐ Yes (If Yes, please indicate when you have taken each below)

HAVE YOU TAKEN?	NO	YES	From Mos./Year	To Mos./Year
Protease Inhibitors:				
Agenerase, amprenavir	☐	☐	__ ____	__ ____
Crixivan, indinavir	☐	☐	__ ____	__ ____
Kaletra, lopinavir/ritonavir	☐	☐	__ ____	__ ____
Viracept, nelfinavir	☐	☐	__ ____	__ ____
Norvir, ritonavir	☐	☐	__ ____	__ ____
Invirase, Fortovase, saquinavir	☐	☐	__ ____	__ ____
Reyataz, atazanavir	☐	☐	__ ____	__ ____
Lexiva, fosamprenavir	☐	☐	__ ____	__ ____
NNRTI's:				
Rescriptor, delavirdine	☐	☐	__ ____	__ ____
Sustiva, efavirenz	☐	☐	__ ____	__ ____
Viramune, nevirapine	☐	☐	__ ____	__ ____
Emtriva, emtricitabine	☐	☐	__ ____	__ ____
Truvada (emtricitabine + tenofovir)	☐	☐	__ ____	__ ____
Epzicom (abacavir + lamivudine)	☐	☐	__ ____	__ ____
NRTI's and NtRTI:				
Ziagen, abacavir, ABC	☐	☐	__ ____	__ ____
Videx, ddI, didanosine	☐	☐	__ ____	__ ____
Epivir, 3TC, lamivudine	☐	☐	__ ____	__ ____
Zerit, d4T, stavudine	☐	☐	__ ____	__ ____
Hivid, ddC, zalcitabine	☐	☐	__ ____	__ ____
AZT, Retrovir, zidovudine	☐	☐	__ ____	__ ____
Combivir (AZT + 3TC)	☐	☐	__ ____	__ ____
Trizivir (AZT + 3TC + ABC)	☐	☐	__ ____	__ ____
Viread, tenofovir	☐	☐	__ ____	__ ____
Fusion Inhibitor:				
Fuzeon, enfuvirtide	☐	☐	__ ____	__ ____
Others: (Please Name)				
Hydrea, hydroxyurea	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____
_____	☐	☐	__ ____	__ ____

IV. LIPODYSTROPHY HISTORY

WEIGHT: Have you noticed a change in your weight since HIV Infection?
☐ No ☐ Yes (If Yes, please estimate the changes and dates.)
(If No, please estimate your current weight on the From line)

From WEIGHT: _____ Pounds DATE: _ _ Month _ _ _ _ Year

To WEIGHT: _____ Pounds DATE: _ _ Month _ _ _ _ Year

To WEIGHT: _____ Pounds DATE: _ _ Month _ _ _ _ Year

FIRST NOTICE: Have you noticed changes in your body fat since HIV Infection?
☐ No ☐ Yes (If Yes, when did you first notice the changes?)

DATE: _ _ Month _ _ _ _ Year

AREAS OF ***FAT LOSS***: Which areas of your body have fat decreases? (Check all that apply)

☐ Face
☐ Chin
☐ Back of Neck
☐ Chest / Breasts
☐ Abdomen / Stomach
☐ Upper Arms
☐ Forearms / Hands
☐ Hips / Buttocks
☐ Thigh / Upper Leg
☐ Calf / Feet

AREAS OF ***FAT GAIN***: Which areas of your body have fat increases? (Check all that apply)

☐ Face
☐ Chin
☐ Back of Neck
☐ Chest / Breasts
☐ Abdomen / Stomach
☐ Upper Arms
☐ Forearms / Hands
☐ Hips / Buttocks
☐ Thigh / Upper Leg
☐ Calf / Feet

SEQUENCE: Was there a sequence or order to the changes of fat loss or gain?
☐ No ☐ Yes (If Yes, Where did you first notice changes?)
If Yes, please number areas of change in order (1,2,3…)

_____Face
_____Chin
_____Back of Neck
_____Chest / Breasts
_____Abdomen / Stomach
_____Upper Arms
_____Forearms / Hands
_____Hips / Buttocks
_____Thigh / Upper Leg
_____Calf / Feet

Please answer as best you can:	NO	YES	Don't Know
Do your *arms* appear *muscular*?	☐	☐	☐
Do your *arms* show *prominent veins*?	☐	☐	☐
Do your *legs* appear *muscular*?	☐	☐	☐
Do your *legs* show *prominent veins*?	☐	☐	☐
Do you have a "*Buffalo Hump*"—Pad of fat on the back of your neck?	☐	☐	☐
Do you have an unusually *fat belly*?	☐	☐	☐
Do you have a *double chin*?	☐	☐	☐
Do your *cheeks* look *hollow* or sunken?	☐	☐	☐

NECK SIZE: Have you noticed a change in your neck size since HIV Infection?

☐ No ☐ Yes (If Yes, please estimate the changes.)

From SIZE: _____ (Inches) DATE: _ _ (Month) _ _ _ _ (Year)

To SIZE: _____ (Inches) DATE: _ _ (Month) _ _ _ _ (Year)

WAIST SIZE: Have you noticed a change in your waist size since HIV Infection?

☐ No ☐ Yes (If Yes, please estimate the changes.)

From SIZE: _____ (Inches) DATE: _ _ (Month) _ _ _ _ (Year)

To SIZE: _____ (Inches) DATE: _ _ (Month) _ _ _ _ (Year)

V. GENERAL MEDICAL HISTORY:

Have you ever had or been told you have?	NO	YES	Don't Know	If Yes, Age of onset
High Cholesterol	☐	☐	☐	_____
High Triglycerides	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Heart Disease				
a. Angina (Chest Pain)	☐	☐	☐	_____
b. Heart Attack	☐	☐	☐	_____
c. Heart Failure	☐	☐	☐	_____
d. Heart Murmur	☐	☐	☐	_____
e. Irregular / Slow Heart Beat	☐	☐	☐	_____
f. Pacemaker	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Claudication (Pain in legs while walking)	☐	☐	☐	_____
Kidney Disease:				
a. Protein in Urine	☐	☐	☐	_____
b. Sugar in Urine	☐	☐	☐	_____
c. Kidney Stones	☐	☐	☐	_____
d. Kidney Failure	☐	☐	☐	_____
High Blood Pressure	☐	☐	☐	_____
Underactive Thyroid (Hypothyroidism)	☐	☐	☐	_____
Overactive Thyroid (Hyperthyroidism)	☐	☐	☐	_____
Arthritis (Rheumatoid or Osteo)	☐	☐	☐	_____
Osteoporosis (Low Bone Density)	☐	☐	☐	_____
Pancreatitis	☐	☐	☐	_____
Major Depression	☐	☐	☐	_____
Suicide Attempt	☐	☐	☐	_____
Anemia	☐	☐	☐	_____
Hepatitis (Type A, B, C, D, or E)	☐	☐	☐	_____
Cancer (Any Type)	☐	☐	☐	_____
Enlarged Liver or Spleen	☐	☐	☐	_____
Drug Allergies If yes, please list_____	☐	☐	☐	_____
Other Allergies If yes, please list_____	☐	☐	☐	_____

Patient Family Medical History

	Yes	No	Don't Know	Family Member
Heart Disease	☐	☐	☐	_____
Stroke	☐	☐	☐	_____
Hypertension	☐	☐	☐	_____
Asthma	☐	☐	☐	_____
Diabetes	☐	☐	☐	_____
Cancer	☐	☐	☐	_____
Kidney Disease	☐	☐	☐	_____
Blood Disorder	☐	☐	☐	_____
Unusual Body Shape	☐	☐	☐	_____
Other _____	☐	☐	☐	_____

VI. PRIOR HOSPITALIZATIONS AND SURGERIES

Have you ever been *hospitalized for any reason*?

☐ No ☐ Yes (If Yes, please detail below)

Problem or Procedure Date

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

VII. WOMEN ONLY (This Page):

MENARCHE: At what age did you first **menstruate**? _____ (Years)

☐ Not yet reached menarche (first menstrual period)

MENSTRUAL PERIODS: Do you have **regular** menstrual periods?

☐ Yes ☐ No (If No, Mark all that apply)

- ☐ Very Heavy Menstrual Periods
- ☐ Long Menstrual Periods (lasting more than 7 days)
- ☐ No Menstrual Periods (over last 3 months)
- ☐ Post-Menopausal or Hysterectomy

When was the start of your **last** menstrual period: _ _ (Month) _ _ (Day) _ _ _ _ (Year)

MENOPAUSE: At what age did you **last** menstruate? _____ (Years)

☐ Not yet reached menopause (last period or hysterectomy)

PREGNANCY:

How many total *pregnancies*? _____

How many total *live births*? _____

How many total *miscarriages*? _____

CONTRACEPTION: Do you currently use **birth control** methods / devices?

☐ No ☐ Yes (If Yes, Mark all that apply)

- ☐ Oral Contraceptives
- ☐ Depo-Provera, Injection Contraception
- ☐ Norplant, Implanted Contraception
- ☐ Barrier Methods (Diaphragm, Condom, Sponge)
- ☐ Intra-Uterine Device (IUD)
- ☐ Rhythm Method (Timing Intercourse to avoid ovulation)
- ☐ Prior Tubal Ligation or Hysterectomy (Surgical Sterilization)

OTHER:

Do you have increased *facial* or *body hair*? ☐ No ☐ Yes

Have you had a *deepening* of your *voice*? ☐ No ☐ Yes

Have you had *polycystic ovarian syndrome*? ☐ No ☐ Yes

BRA SIZE: Have you noticed a change in your bra size since HIV Infection?

☐ No ☐ Yes (If Yes, please estimate the changes.)

From SIZE: _____ (Inches/Cup) DATE: _ _ (Month) _ _ _ _ (Year)

To SIZE: _____ (Inches/Cup) DATE: _ _ (Month) _ _ _ _ (Year)

VIII. MEDICATIONS

ARE YOU OR HAVE YOU EVER TAKEN?	NO	YES	If YES, How Long (Yrs)	If NOT ANY MORE, How long ago (Yrs)
Hormones:				
Levothyroxine, Synthroid, Levoxyl, Levotec	☐	☐		
Estrogens (Oral Contraceptive or Hormone Replacement therapy)	☐	☐		
Progesterone (Oral Contraceptives)	☐	☐		
Anabolic Steroids, Testosterone, Oxandralone	☐	☐		
Corticosteroids (Prednisone, Dexamethasone, Decadron, Solu-Medrol, Megace)	☐	☐		
DHEA	☐	☐		
Andro, Androstendione	☐	☐		
Other _____	☐	☐		
Cholesterol Lowering Medications:				
Statins, Zocor, Pravachol, Lescol, Lipitor, Mevacor, Crestor	☐	☐		
Fibrates (Lopid, Tricor, gemfibrozil, fenofibrate)	☐	☐		
Niacin, nicotinic acid	☐	☐		
Colestipol, cholestyramine, colsevelam, Welchol, Questran, Colestid LoCholest	☐	☐		
Fish Oil	☐	☐		
Zetia	☐	☐		
Other _____	☐	☐		
Diabetic Medications:				
Insulin	☐	☐		
Glyburide, glipizide, Glucotrol, Glimeperide, Amaryl, Micronase, DiaBeta, Glucovance	☐	☐		
Metformin, Glucophage, Glucovance, Glycon	☐	☐		
Avandia, Actos, rosiglitazone, pioglitazone	☐	☐		
Meteglinide, repaglinide, Prandin	☐	☐		
Acarbose, Glysef, Precose, migitol	☐	☐		
Other _____	☐	☐		
Others:				
Interleukin-2, Proleukin, aldesleukin	☐	☐		
Nizoral, Ketoconazole	☐	☐		
Other _____	☐	☐		

MEDICATIONS: Please list all medications, including herbs, supplements and over-the-counter products, you are currently taking:

Name Dose Times per day

IX. SOCIAL HISTORY

ALCOHOL: Do you drink **alcoholic** beverages?

☐ No ☐ Yes If Yes, How many drinks per week on average?_____

Assume 1 drink equals 12 oz. Beer, 4 oz. Wine, or 1 oz Liquor

SMOKING:

Did you **ever** smoke? ☐ No ☐ Yes

If *Yes,*

a. How many packs per day at the **most**?

☐ 0-½ ☐ ½-1 ☐ 1-1½ ☐ 1½-2 ☐ >2

b. How old were you when you started? _____ (Years)

c. Do you **still** smoke? ☐ Yes ☐ No

If *Yes*,

How many packs per day?

☐ 0-½ ☐ ½-1 ☐ 1-1½ ☐ 1½-2 ☐ >2

If *No*,

How old were you when you stopped? _____ (Years)

RECREATIONAL DRUGS:

Do you currently use *recreational drugs*, such as cocaine, amphetamines, or marijuana?

☐ No ☐ Yes If Yes, How many times per week on average?_____

Do you currently use *intravenous (IV) drugs*, like heroin?

☐ No ☐ Yes If Yes, How many times per week on average?_____

EXERCISE:

Do you exercise *regularly*?

☐ No ☐ Yes If Yes, Mark all that apply with how often you exercise.

Type of Exercise:	Yes	Hours per Week
Weight Training / Lifting	☐	_____
Mild Aerobic (Walking, Light Sports)	☐	_____
Moderate / Heavy Aerobic (Running, Hard Sports, Jogging)	☐	_____
Flexibility (Stretching, Yoga)	☐	_____

DIET AND WEIGHT:

Were you *overweight as a child*? ☐ No ☐ Yes

What has been your *maximum weight (*excluding any pregnancies)? _____ (Pounds)

At what age were you at your maximum weight? _____ (Years)

Do you follow or have you ever followed one of the *diets* listed below?

☐ No ☐ Yes If Yes, please specify type and give general details

a. ☐ Low cholesterol or low fat _____

b. ☐ Diabetic _____

c. ☐ Low salt _____

d. ☐ Weight reduction _____ (Low Calorie)

e. ☐ Vegetarian _____

f. ☐ Low Carbohydrate _____ (Atkin's, etc.)

g. ☐ Macrobiotic _____

h. ☐ Other _____ (Cabbage/Grapefruit, etc.)

THANK YOU FOR PARTICIPATING IN THIS STUDY ON LIPODYSTROPHY