



46515

# PROVIDER QUESTIONNAIRE

## TO BE COMPLETED BY STUDY COORDINATOR.

DATE OF VISIT:  /  /

PATIENT ID:

PATIENT NAME

PROVIDER NAME

SPECIALTY:  Infectious Disease  General Medicine  Other

DEGREE:  MD (See Status)  RN  Other

MD STATUS:  Resident  Fellow  Attending

All of the following questions refer to the patient listed above. Please answer the questions to the best of your ability based on what you know about the patient. Please make your best guess. Please do not ask the patient. (We are asking the patient some of these questions as well.) Please fill in  the circle for each of the following:

1a. What is the patient's race?  White  Black  Hispanic  Other

1b. What is the patient's gender?  Male  Female

1c. What is the patient's exposure?  IVDU  Heterosexual  Homosexual  Transfusion  Other

2. Are you the patient's primary care provider?  Yes  No

3. How close is your relationship with this patient?  Very close  Somewhat close  Not close at all

4. How sick is this patient?  
 Near death  Very sick  Moderately sick  Somewhat sick  Not sick at all

5. In your best judgement, please estimate the percentage of probability that this patient will live 5 and 10 years.  
 % probability this patient will live 5 yrs.  % probability this patient will live 10 yrs.

6. When was the last time this patient missed any of their HIV antiviral medications?  
 Within past week  1-2 wks ago  2-4 wks ago  1-3 mos. ago  > 3 mos. ago  Never missed

7. When was the last time this patient missed any of their medications for comorbid conditions?  
 Within past week  1-2 wks ago  2-4 wks ago  1-3 mos. ago  > 3 mos. ago  Never missed

8. Please mark the following behaviors this patient practices:

	Past	Present	Never
Smokes cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinks too much alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uses illegal drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

9. Does this patient have cognitive impairments or dementia?  A great deal  Some  Slight  None

10. Please mark the following psychiatric problems this patient has. (To the best of your knowledge)

	Yes	No	Don't Know		Yes	No	Don't Know
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Schizophrenia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Manic Depression/Bipolar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Anxiety	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>



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11. Please mark the **symptoms** this patient has had in the last 4 weeks from the following list. (To the best of your knowledge).

	Yes	No	Don't Know		Yes	No	Don't Know
Fatigue or loss of energy -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Skin problems such as rash, dryness or itching --	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Fevers, chills, or sweats -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cough or trouble catching breath -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Dizziness or lightheadedness -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Headache-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Pain, numbness or tingling in hands or feet -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Loss of appetite or change in the taste of food--	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Trouble remembering -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bloating, pain or gas in stomach -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nausea or vomiting -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Muscle aches or joint pain -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diarrhea or loose bowel movements--	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Problems with having sex such as loss of interest or lack of satisfaction -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt sad, down or depressed -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Changes in the way body looks such ,as fat deposits or weight gain -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Felt nervous or anxious -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Problems with weight loss or wasting -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Difficulty falling or staying asleep ----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hair loss or changes in the way hair looks -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

12. Please mark all of the following **HIV-related comorbid conditions** this patient has ever had. (To the best of your knowledge).

	Yes	No	Don't Know		Yes	No	Don't Know																				
PCP -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Histoplasmosis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
KS-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Enteric Parasites (Cryptosporidia, etc.) -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
MAI or MAC -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bacterial Pneumonia -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Esophageal Candidiasis/Thrush -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bacterial Sepsis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
TB-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Lymphoma -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
CMV Retinitis/Disseminated -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other AIDS-Related Cancers -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Shingles/Herpes Simplex -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HIV Dementia -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Toxoplasmosis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	HIV Wasting -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Coccidiomycosis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Peripheral Neuropathy-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Cryptococcus -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																						

13. Please mark all the following **general comorbid conditions** this patient has ever had. (To the best of your knowledge).

Conditions due to HIV medications should be included here.

	Yes	No	Don't Know		Yes	No	Don't Know																				
Abnormal liver function tests -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperlipidemia-----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Hepatitis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Peripheral Vascular -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Liver Failure/Cirrhosis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Myocardial Infarction/CAD -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Pancreatitis -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Congestive Heart Failure -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Pulmonary Disease, not requiring oxygen -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Stroke/TIA -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Pulmonary Disease, requiring oxygen -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes Mellitus, diet controlled -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Renal Insufficiency -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Diabetes Mellitus, requiring medication -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Renal Failure (requiring dialysis) ---	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cancer (Other than KS, Lymphoma, or cervical)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>																				
Hypertension -----	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other	<table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;"></td> </tr> </table>																						

THANK YOU VERY MUCH