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 anitiviral 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	○	○	○
Drinks too much alcohol	○	○	○
Uses illegal drugs	○	○	○

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	○	○	○	Schizophrenia	○	○	○
Manic Depression/Bipolar	○	○	○	Anxiety	○	○	○

Please continue on the reverse side

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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	○	○	○	Skin problems such as rash, dryness or itching	○	○	○
Fevers, chills, or sweats	○	○	○	Cough or trouble catching breath	○	○	○
Dizziness or lightheadedness	○	○	○	Headache	○	○	○
Pain, numbness or tingling in hands or feet	○	○	○	Loss of appetite or change in the taste of food	○	○	○
Trouble remembering	○	○	○	Bloating, pain or gas in stomach	○	○	○
Nausea or vomiting	○	○	○	Muscle aches or joint pain	○	○	○
Diarrhea or loose bowel movements	○	○	○	Problems with having sex such as loss of interest or lack of satisfaction	○	○	○
Felt sad, down or depressed	○	○	○	Changes in the way body looks such ,as fat deposits or weight gain	○	○	○
Felt nervous or anxious	○	○	○	Problems with weight loss or wasting	○	○	○
Difficulty falling or staying asleep	○	○	○	Hair loss or changes in the way hair looks	○	○	○

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	○	○	○	Histoplasmosis	○	○	○
KS	○	○	○	Enteric Parasites (Cryptosporidia, etc.)	○	○	○
MAI or MAC	○	○	○	Bacterial Pneumonia	○	○	○
Esophageal Candidiasis/Thrush	○	○	○	Bacterial Sepsis	○	○	○
TB	○	○	○	Lymphoma	○	○	○
CMV Retinitis/Disseminated	○	○	○	Other AIDS-Related Cancers	○	○	○
Shingles/Herpes Simplex	○	○	○	HIV Dementia	○	○	○
Toxoplasmosis	○	○	○	HIV Wasting	○	○	○
Coccidiomycosis	○	○	○	Peripheral Neuropathy	○	○	○
Cryptococcus	○	○	○	Other			

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	○	○	○	Hyperlipidemia	○	○	○
Hepatitis	○	○	○	Peripheral Vascular	○	○	○
Liver Failure/Cirrhosis	○	○	○	Myocardial Infarction/CAD	○	○	○
Pancreatitis	○	○	○	Congestive Heart Failure	○	○	○
Pulmonary Disease, not requiring oxygen	○	○	○	Stroke/TIA	○	○	○
Pulmonary Disease, requiring oxygen	○	○	○	Diabetes Mellitus, diet controlled	○	○	○
Renal Insufficiency	○	○	○	Diabetes Mellitus, requiring medication	○	○	○
Renal Failure (requiring dialysis)	○	○	○	Cancer (Other than KS, Lymphoma, or cervical)	○	○	○
Hypertension	○	○	○	Other			

THANK YOU VERY MUCH