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Tuberculosis (TB) treatment outcomes in adult TB patients attending a rural HIV cllinic in South Africa (Bushbuckridge).

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Adult Wellness Dgraphics

Visit 1 Socio Demographic Form Study ID

Patient Initials First Middle Last

Visit Date: dd mm yyyy

1. Was a Consent Form signed? Yes 1 No 0 → **Do Not continue with this form** — Consent

2. Gender? Male 0 Female 1 — Gender

3. Date of Birth? DOBd dd DOBm mm DOBy yyyy

OR, if Date of Birth NOT available, please provide Estimated Age.

4. Estimated Age — EstAge

5. Race — Race
- 0 Black / African
- 1 Coloured
- 2 White
- 3 Indian
- 4 Asian
- 5 Other

6. Village or Town where you live: _____ — Town

7.What is the main material that the walls of your house are built of? — Walls
- 0 House/Townhouse/Flat - Family or Self owned (Brick)
- 1 House/Townhouse/Flat - Renting (Brick)
- 2 Hostel (Brick)
- 3 Shack - Informal settlement
- 4 Shack - Backyard
- 5 Hut - Family or Self owned
- 6 Hut - Renting
- 7 Hut - Other
- 8 Other, Specify _____ — WallsOther

8. What is the main source of drinking water? — Water
- 0 Running tap water in dwelling
- 1 Running tap water on site
- 2 Water Tank/Carrier
- 3 Piped to public tap/kiosk
- 4 Borehole with hand pump on site
- 5 Borehole with handpump-communal
- 6 Borehole with engine-communal
- 7 Rain - water tank
- 8 Flowing water
- 9 Dam/Pool/Stagnant water
- 10 Well(non-borehole) on site
- 11 Well(non-borehole) communal
- 12 Protected Spring
- 13 Unprotected Spring
- 14 Other, specify _____ — WaterOther

9. Highest Level of Education?
- 0 None — EduLev

If patient has a school education, but NO tertiary education, provide highest school grade achieved. (0 - 12) — EduLevSpec
- 13 Tertiary Education — EduLev

10. Your Occupational status? *(Mention all types applicable)*

Self Employed	1 Yes 0 No	SelfEmployed
Student	1 Yes 0 No	Student
Salaried worker	1 Yes 0 No	Salaried
Unemployed and able/willing to work	1 Yes 0 No	UnempAble
Unemployed and unable/not willing to work	1 Yes 0 No	UnempUnable
Other, specify _____		OtherOcc

11. Specify your income from all non-work related sources. *(Mark all that apply)*

	Household	Personal	
None	1 Yes 0 No	1 Yes 0 No	NoIncomeHH/P
Old Age Pension	1 Yes 0 No	1 Yes 0 No	OldPensionHH/P
Disability Grant	1 Yes 0 No	1 Yes 0 No	DGrantHH/P
Child Support Grant	1 Yes 0 No	1 Yes 0 No	CSGrantHH/P
Private/Work related Pension	1 Yes 0 No	1 Yes 0 No	PensionHH/P
Financial or non-financial gifts from household member	1 Yes 0 No	1 Yes 0 No	GiftsHH/P
Financial or non-financial gifts from non-HH member	1 Yes 0 No	1 Yes 0 No	GiftsNonHH/P
Receiving dividends from investments	1 Yes 0 No	1 Yes 0 No	InvestmentHH/P
Receiving money from business	1 Yes 0 No	1 Yes 0 No	Business HH/P
Other	1 Yes 0 No	1 Yes 0 No	OtherIncomeHH/P

12. How many people live in your household? ☐☐ — HHpeople

13. How many rooms are there in your house? ☐☐ — Rooms

14. Who is the head of your household?

6 Self

If not self

0 Female (18 - 60 Years)
1 Male (18 - 60 Years)
2 Female child less than 18 Years
3 Male child less than 18 Years
4 Female > 60 Years
5 Male > 60 Years

— HHhead

15. What is your marital status?

0 Never Married
1 Divorced
2 Separated
3 Widowed
4 Married: Legal
5 Married: Traditional
6 Living together, not married
7 Same sex partner

— Mstatus

16. When were you first diagnosed with HIV? HIVm ☐☐ *mm* HIVy ☐☐☐☐ *yyyy*

17. When did you start attending this Wellness Clinic HWCm ☐☐ *mm* HWCy ☐☐☐☐ *yyyy*

18. How many times have you attended this Clinic in the past? ☐☐ — WCVisits

19. Have you ever smoked, either in the past or now? 1 Yes 0 No, **skip to question 20** — Smoked

If YES

19.1 How many cigarettes/pipes a day? — Cigarettes

19.2 Year started? *yyyy* — CBegYr

19.3 Have you stopped smoking permanently? 1 Yes 0 No — CStopped

Year stopped smoking? *yyyy* — CStopYr

20. Have you ever taken alcohol? 1 Yes 0 No, **skip to question 21** — Alcohol

If YES

20.1 How many drinks a week? — Drinks

20.2 Year started? *yyyy* — ABegYr

20.3 Have you stopped drinking? 1 Yes 0 No — AStopped

Year stopped drinking? *yyyy* — AStopYr

21. Have you ever smoked dagga, marijuana, matekwane ? 1 Yes 0 No, **skip to question 22** — Dagga

If YES

21.1 Please complete how often dagga is smoked. — DaggaOften

Past usage	Current usage			
In the past	Occasionally	Once a week	Not every day but more than once a week	Every day
☐	☐	☐	☐	☐

22. Please give height without shoes. cm — Height

Patient Initials [First] [Middle] [Last]

Special instructions: *For Visit 1, please ask questions in relation to past year. For FU visits, ask question since previous study visit.*

	Visit 1	FU	FU	FU	
1. Date of visit:	dd mm yyyy	dd mm yyy	dd mm yyyy	dd mm yyyy	
2. How many times has the patient attended this clinic since their previous study visit?					USVisits
3. Whom of the following did the patient visit for healthcare? *(Over past year for visit 1 or since their previous visit for FU visits)*	*If YES, specify number of times*	*If YES, specify number of times*	*If YES, specify number of times*	*If YES, specify number of times*	
3.1 Nearest Clinic NClinic	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	NCVisits
3.2 Another Clinic AClinic	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	ACVisits
3.3 Doctor (GP) GPractitioner	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	GPVisits
3.4 Traditional Healer TradHealer	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TradVisits
3.5 This Hospital THospital	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	THospVisits
3.6 Another Hospital AHospital	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	AHospVisits
3.7 Faith Healer FaithHr	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FaithHrVisits
3.8 Homeopath HomeoDr	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	HomeoDrVisits
3.9 Chiropractitioner Chiropractitioner	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	ChiroVisits
3.10 Other, specify					
4. Have you been hospitalized in the past or since last study visit?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Hospitalised
4.1 If YES, specify number of times **PLEASE ADD THE ADMISSION FORM TO CRF**					TimesHosp
5. Do you need help with daily activities from someone else?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	NeedHelp
5.1 If YES, with what do you need help? *(Mark all activities)*					
5.1.1 Cooking	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Cook
5.1.2 Cleaning	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Clean
5.1.3 Washing and dressing self	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Wash
5.1.4 Eating	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Eat
5.1.5 Taking medicines	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Medicines
5.1.6 Walking around house	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Walk
5.1.7 Toilet	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Toilet
5.1.8 Go to other places outside house	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	GetOut
5.1.9 Other, Specify					OtherHelp

	Visit 1	FU	FU	FU	
5.2 Who helps you with these activities?					
5.2.1 Mother	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	MotherHelp
5.2.2 Father	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FatherHelp
5.2.3 Partner	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	PartnerHelp
5.2.4 Sibling	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	SiblingHelp
5.2.5 Child	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	ChildHelp
5.2.6 Other family member	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	OFMHelp
5.2.7 Friend	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FriendHelp
5.2.8 Health Worker	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	HWorkerHelp
5.2.9 NGO/CBO/Church	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	NGOHelp
5.2.10 Community volunteer	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CVHelp
5.2.11 Other, Specify	_____	_____	_____	_____	Otherhelper
5.3 How many hours per day do other people help you with these activities?					Hours
6. Did any of the following change since the previous study visit?					
6. 1 Education or employment?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	EduLevel
6.2 Household head or marital status?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	HHHead
6.3 Housing?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Housing
6.4 Water source?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CWater
7. How many drinks of alcohol do you take per week? *(if none enter 00)*					Drinks
8. How many cigarettes/pipes do you smoke per day? *(if none enter 00)*					Cigarettes
9. What is your total personal monthly earnings from any source? *(Rands)*					Income
10. What is your household's total monthly earnings? *(Rands)*					HHIncome
11. In the past week, how many times did anyone at your house miss a meal because there was no food?					MealMissed
12. Have you disclosed your HIV status to anyone	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Disclosed
12.1 If YES, Please provide date and to whom did you disclose? Disclosedm m	mm yyyy	mm yyyy	mm yyyy	mm yyyy	Disclosedyyyy
1.2.1.1 Sex Partner	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	DisPartner
1.2.1.2 Family	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	DisFamily
1.2.1.3 Friend	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	DisFriend
1.2.1.4 Other	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	DisOther
Other specify please:					DisOtherSpec
13. Does this patient qualify for a disability grant?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	QualifyGrant
13.1 Please give date applied for dis-ability grant. DGrantMM	mm yyyy	mm yyyy	mm yyyy	mm yyyy	DGrantYY

 StudyID

Tuberculosis	Visit 1				
This section should only be filled in at visit 1					
1. Have you been diagnosed and treated for TB before?	1 Yes 0 No				TBTreatment
1.1 If Yes, How many times have you been treated for TB in the past?					TBNumber
1.2 If YES, from what date to what date? (*Please provide start and end date of last TB treatment)*	Start date mm yyyy (Startm, Starty) **to** End date mm yyyy (Endm, Endy)				
2. Have you taken any preventive treatment for TB before?	1 Yes 0 No				TBPrevention
ClinicalTBVisits					
This section should be completed at each visit.					
	Visit 1	**FU**	**FU**	**FU**	
1. Is TB suspected at this visit?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TBSuspect
1.1 If YES, state reason. *(List all relevant options)*					
1.1.1 Productive cough	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Cough
1.1.2 Haemoptysis	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Haemoptysis
1.1.3 Night sweats or fever	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Fever
1.1.4 Weight loss	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	WeigtLoss
1.1.5 Other	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Other
1.2 If YES, Was sputum collected *(note date and results on LAB form)*	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Sputum
1.3 If YES, was CXR done?.	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CXRdone
1.4 Was TB diagnosed either here or elsewhere since previous study visit?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TBDiagnosed
1.4.1 If YES, please provide date of diagnoses.		dd mm yyyy	dd mm yyyy	dd mm yyyy	TBDxd/TBDxm/ TBDxy
1.4.2 If YES, how was the diagnosis made?					
1.4.2.1 Sputum AFB positive?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	AFBpositive
1.4.2.2 Culture positive?		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CulturePos
1.4.2.3 CXR		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CXR
1.4.2.4 Bactec Culture positive		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Bactec
1.4.2.5 FNA lymphnode positive		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FNA
1.4.2.6 Clinically only		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Clinical
1.4.2.7 Other		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	OtherDx
1.4.3 If YES: **1.4.3.1 Date treatment started**		dd mm yyyy	dd mm yyyy	dd mm yyyy	TreatSDD/TreatSMM TreatSYYYY
1.4.3.2 Date treatment stopped		dd mm yyyy	dd mm yyyy	dd mm yyyy	TreatEDD/TreatEMM TreatESYYYY

	Visit 1	FU	FU	FU	
1.4.4 Outcome:					
1.4.4.1 Treatment ongoing		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TOngoing
1.4.4.2 Treatment completed		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TCompleted
1.4.4.3 Treatment interrupted		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TInterrupted
1.4.4.4 Patient died on treatment		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TDied
1.4.4.5 Transferred out		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	TTransferred
1.4.4.6 Other, please specify					TOther
2. TST Reading in mm (do once only)	TST	**Give date of TST reading.** TSTd (dd) TSTm (mm) TSTy (yyyy)			

ClinicalReproductive

	Visit 1	FU	FU	FU	
1. Was family planning discussed with the patient at this visit?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FPDiscussed
For Female Patients ONLY					
2. Are you pregnant now?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Pregnant
3. Are you using any methods to prevent pregnancy	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	FPprevention
3.1 If YES, which of the following?					
3.1.1 Injectable(Nuristerate or Depo)	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	NurDepo
3.1.2 Pills	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Pills
3.1.3 Barrier method (condom/diaphram)	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Barrier
3.1.4 Intra-uterine device (loop)	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Loop
3.1.5 Traditional methods	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Traditional
3.1.6 Other, please specify					OtherFP

Sexually Transmitted Infections	Visit 1	FU	FU	FU	
1. Have you been treated for STI's in the past or since the last visit?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	STIyn
1.1 If YES, how many times were you treated for STI's?					STItimes
1.2 If YES, what symptoms *(List all)*					
1.2.1 Genital discharge		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Discharge
1.2.2 Genital rash/blisters		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Rash
1.2.3 Genital sores		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Sores
1.2.4 Lower abdominal pain (Females)		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	LAP
1.2.5 Pubic Lice		1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Lice
2. How many discrete episodes of STI did you have since the last visit?					STIDiscrete
3. Any STI Symptoms at present?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	STISymptoms
3.1 If YES, what symptoms (list all)					
3.1.1 Genital discharge	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Discharge1
3.1.2 Genital Rash/blisters	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Rash1
3.1.3 Genital sores	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Sores1
3.1.4 Lower Abdominal pain (Females)	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	LAP1
3.1.5 Pubic Lice	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Lice1
3.1.6 Other	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	STISymptoms

*** Discrete episodes = STI that resolved completely. Either because it was treated or resolved spontaneosly.**

Condom Use

1.1 How often do you use condoms with your regular partner?					
1.1.1 Always	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondregAlways
1.1.2 Occasionally	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondregOccasional
1.1.3 Never	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondregNever
1.1.4 Do not have a regular partner	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondregNoPartner
1.2 How often do you use condoms with your casual partners?					
1.2.1 Always	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondcasAlways
1.2.2 Occasionally	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondcasOccasional
1.2.3 Never	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondcasNever
1.2.4 Do not have casual partners	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CondcasNoPartner
1.3 How many sexual partners did you have in the past 6 months?					HowManyPartners
1.4 With 4 of the most recent partners, what is the pattern of condom use?					
1.4.1.....Partner 1	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	RecentPartner1
1.4.2 .....Partner 2	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	RecentPartner2
1.4.3.....Partner 3	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	RecentPartner3
1.4.4.....Partner 4	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	1 Always 2 Occasional 3 Never	RecentPartner4
1.5 Did you use a condom with the 4 most recent partners the last time you had sex?					
1.5.1 Partner 1	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CasualPartner1
1.5.2 Partner 2	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CasualPartner2
1.5.3 Partner 3	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CasualPartner3
1.5.4 Partner 4	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CasualPartner4

CPT Preventive Therapy	Visit 1	FU	FU	FU	
1. Is patient on CPT Preventive Therapy?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	CPTTreat
1.1 Start date of treatment	dd mm yyyy	dd mm yyyy	dd mm yyyy	dd mm yyyy	Startd/Startm/Starty
1.2 Number of months on treatment					Months
1.3 How many doses of CPT did you miss in the last 3 days?					MissedDoses
1.4 Progress: *(Select only one)*					
1.4.1 Ongoing	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Progress
1.4.2 Stopped due to side effects	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	
1.4.3 Treatment Interrupter	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	
1.4.4 Death	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	
1.4.5 Stopped due to clinical improvement	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	
1.4.6 Other, please specify					ProgressOther
1.5 Any side effects or symptoms that might be attributed to CPT?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	SideEffects
1.5.1 If YES, please specify symptoms					
1.5.1.1 Skin Rash	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	SkinR
1.5.1.2 Nausea	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Nausea
1.5.1.3 Allergic reaction	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	AllReac
1.5.1.4 Jaundice	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Jaundice
1.5.1.5 Peripheral neuropathy	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	PerN
1.5.1.6 Other, please specify					SideEffOther
1.6 Is the patient taking other medications *(not including CTX, INH)*	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	OtherMeds
1.6.1 Antiretrovirals	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Antiretro

Please complete ARV Form

Eye Symptoms

Please complete all	Visit 1 Left Eye	Visit 1 Right Eye	FU Left Eye	FU Right Eye	FU Left Eye	FU Right Eye	FU Left Eye	FU Right Eye	
1.1 Itchy Eye	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	ItchyL/ItchyR
1.2 Dryness	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	DrynessL/DrynessR
1.3 Sense of foreign body in eye	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	ForeignL/ForeignR
1.4 Visual deterioration	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	VisualDeteriorL/ VisualDeteriorR
1.5 Blurring of Vision	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	BlurringL/R
1.6 Cosmetic / redness	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	CosmeticRedL/R
1.7 Other symptoms	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	OtherSymptomsL/R
1.7.1 Other symptoms specify:									OtherSymp-tomsSpecifyL/R
1.8 Duration of Symptoms									DurationL/R

Eye Signs

Please complete all	Visit 1 Left Eye	Visit 1 Right Eye	FU Left Eye	FU Right Eye	FU Left Eye	FU Right Eye	FU Left Eye	FU Right Eye	
2.1 Distinct triangular shaped vascular ingrowth with apex toward the cornea but NOT on the cornea.	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	DTSVNotCorL/R
2.2 Extent of involvement: Nasal side = 1 Temporal side = 2 Both sides = 4									ExtentInvolveL/R
2.3 Raised pearly white mass NOT on cornea.	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	RaisedpwmassL/R
2.4 Distinct triangular shaped vascular ingrowth with apex toward the cornea ON the cornea.	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	DTSVCorL/R
2.5 Raised white mass ON cornea	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	RWMonCorneaL/R
2.6 Other eye signs present	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	Yes 1 No 0	OtherSignsL/R
2.7 Other eye signs specify									OtherSigns-SpecifyL/R
If any signs are present:									
2.8 Visual acuity without glasses or contact lenses	6	6	6	6	6	6	6	6	VisualAcuityL/R
2.9 Date referred for biopsy	dd mm yyyy		dd mm yyyy		dd mm yyyy		dd mm yyyy		Biopsyd/Biop-sym/Biopsyy

Anthropomorphic measurements	Visit 1	FU	FU	FU	
Waist measurement	cm	cm	cm	cm	Waist
Hip measurement	cm	cm	cm	cm	Hip
Blood Pressure measurements (Last of three with patient sitting down for at least 5 mins)	Systolic / Diastolic	Systolic / Diastolic	Systolic / Diastolic	Systolic / Diastolic	BPSys / BPDia
Urine dipstix Protein (0 - +++)	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	UrineProtein
Urine dipstix Blood (0 - +++)	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	0 None 1 + 2 ++ 3 +++	UrineBlood
Facial Lipo Atrophy Grade (0-4)	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	0 1 2 3 4	FacialLipo
Creatinine Date Taken	dd mm yyyy		dd mm yyyy		Creatinined/Creatininem/Creatininey
Random cholesterol Date Taken	dd mm yyyy		dd mm yyyy		RandomCholesd/RandomCholesm/RandomCholesy
Cervical smear Taken	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	1 Yes 2 No	Cervical
Date Cervical smear Taken	dd mm yyyy	dd mm yyyy	dd mm yyyy	dd mm yyyy	Cervicald/Cervicalm/Cervicaly

Diagnosis	Visit 1	FU	FU	FU	
1. What is the diagnosis at this visit? (Use Codes)	.	.	.	.	Diagnosis
2. Were LAB investigations done?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	Lab

Opportunistic Infections and Staging

WHO Clinical Staging	[Give Date of Next Positive Findings (DD/MM/YY)]						
		FIRST VISIT:		**Follow up Date:** DD MM YY	**Follow Up Date:** DD MM YY	**Follow Up Date:** DD MM YY	
Stage	History And Clinical Features	**Present at Visit 1**	**Date When Started**	**Date When Started**	**Date When Sx Started**	**Date When Sx Started**	
WHO Stage 1 Asymptomatic	No Symptoms NoSymptoms	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	NoSymptomsD,M,Y
	Persistent Generalized Lymphadenopathy PGL	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	PGLD,M,Y
WHO Stage 2 Mild Disease	Weight Loss < 10% Body Weight BWLten	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	BWLtenD,M,Y
	Skin Rash, Patches Or Plaques RPP	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	RPPD,M,Y
	Prurigo (Chronic Itchy Skin) Prurigo	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	PrurigoD,M,Y
	Herpes Zoster within last 5 years UHZ	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	UHZD,M,Y
	Recurrent upper respiratory tract infections. RS	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	RSD,M,Y
WHO Stage 3 Moderate Disease	Weight Loss >10% Body Weight BWGten	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	BWGtenD,M,Y
	Unexplained Fever > 1month UF	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	UFD,M,Y
	Oral Candidiasis OC	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	OCD,M,Y
	Vulvo-Vaginal Candidiasis > 1 Month VVC	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	VVCD,M,Y
	Oral Hairy Leucoplakia OHL	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	OHLD,M,Y
	Pulmonary TB Within The Past Year PTB	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	PTBD,M,Y
	Pneumonia Or Other Serious Bacter Infection SBI	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	SBID,M,Y
	Diarrhea > 1month Diarrhea	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	DiarrheaD,M,Y
	Bedridden <50% Of Day Most Previous Month Bedridden	☐ Yes ☐ No	DD MM YY	DD MM YY	DD MM YY	DD MM YY	BedriddenD,M,Y

Opportunistic Infections and Staging

WHO Stage 4 Severe Disease

WHO Clinical Staging [Give Date of Next Positive Findings (DD/MM/YY)]

	FIRST VISIT:		Follow up	Follow Up	Follow Up	
Extra pulmonary TB	EPTB	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	EPTBD,M,Y
Esophageal Candida	EC	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY ECD,M,
Herpes Simplex > 1 Month (Skin/mouth/nose/eye)	HS	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY HSD,M,
Pneumocystis Pneumonia	PP	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY PPD,M,Y
Kaposi's Sarcoma	KS	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY KSD,M,Y
HIV Wasting Syndrome *	WSyndro	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY WSyndromD,M,Y
Bedridden > 50% Of Day In Month	Bedridden2	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY Bedridden2D,M,Y
Cryptococcosis extra pulmonary	CEP	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY CEPD,M,Y
Toxoplasmosis of the brain	TOCBrain	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY TOCBrainD,M,Y
HIV Encephalopathy / Demer	Dementia	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY DementiaD,M,Y
Cryptosporidiosis with diarrhea	CryptoDia	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY CryptoDiaD,M,Y
Lymphoma	Lymphoma	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY LymphomaD,M,Y
Atypical mycobacteriosis ** (non tuberculosis)	AtypMyco	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY AtypMycoD,M,Y
Non-typhoid Salmonella sep	NoNTypSal	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY NoNTypSalD,M,Y
Any disseminated endemic myc	AnyDis	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY AnyDisD,M,Y
Progressive multifocal leucoencephalopathy	ProgressMulti	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY ProgressMultiD,M,Y
Cytomegalovirus other tha node	Cytemega	☐Yes ☐No	DD MM YY	DD MM YY	DD MM YY	DD MM YY CytemegaD,M,Y
Other (specify)						OtherSx
Weight (Kg)						
WHO stage today						

* HIV wasting syndrome = weight loss > 10% body weight plus chronic diarrhea (> 1 month) or chronic weakness and fever (> 1 month)

** Mycobacterum avium couplex br hausassii

Note: Please provide the last WHO stage in which symptoms appear at 'WHO stage today'.

Weight

WHOstage

Hospital

Study ID

Admission Form (Hospitalization)

Patient Initials First Middle Last

1. Date of admission	dd mm yyyy	Admd/Admm/Admy
2. Name of facility admitted to:		
2.1 Chris Hani Baragwanath	1 Yes 0 No	ChrisHani
2.2 Tintswalo	1 Yes 0 No	Tiniswalo
2.3 Other, please specify		OtherFacility
3. Date of discharge	dd mm yyyy	Dischd/Dischm/ Dischy
4. Outcome *(Specify only one outcome)*		
4.1 Improved	1 Yes 0 No	Outcome
4.2 Condition unchanged	1 Yes 0 No	
4.3 Deteriorated	1 Yes 0 No	
4.4 Died in hospital	1 Yes 0 No	
4.5 Absconded	1 Yes 0 No	
4.6 Other, please specify		OutOtherSpecify
5. Discharge diagnoses		
5.1 TB, pulmonary	1 Yes 0 No	TBPulmonary
5.2 TB, extra pulmonary	1 Yes 0 No	TBXPulmonary
5.3 Pneumonia, PCP	1 Yes 0 No	PneumoniaPCP
5.4 Pneumonia, other	1 Yes 0 No	PneumoniaOther
5.5 Meningitis, Cryptococcus	1 Yes 0 No	MeningitisCryp
5.6 Meningitis, Bacterial	1 Yes 0 No	MeningitisOther
5.7 Sepsis / Other bacterial infection	1 Yes 0 No	Sepsis
5.8 Diarrhea	1 Yes 0 No	Diarrhea
5.9 Antiretroviral treatment related	1 Yes 0 No	Antiretrovirals
5.10 Other, please specify		DisOtherSpecify

Adult Wellness Study Termination Form

Termination

Study ID | | | | | | |

To be completed at study termination

Patient Initials [ ] *First* [ ] *Middle* [ ] *Last*

1. Date terminated from study	[ ][ ] [ ][ ] [ ][ ][ ][ ] *dd* *mm* *yyyy*	TermD/TermM/TermY
2. Reason for study termination:	[0] Died [1] Withdrew from study [2] Unable to trace, presumed dead [3] Unable to trace, other reason [4] Other, please specify _____	TerminationReason OtherSpec
If patient withdrew from study, please provide reason		

If Patient DIED, please provide information below:

3. Date of death?	[ ][ ] [ ][ ] [ ][ ][ ][ ] *dd* *mm* *yyyy*	Deathd/Deathm/Deathy
4. Is a death certificate available?	[1] Yes [0] No	DCertificate
5. What was the cause of death - as on death certificate: 5.1 Cause		DCause
5.2 Contributing		DContributing
5.3 Underlying		DUnderlying
6. Was death HIV related?	[1] Yes [0] No	HIVRelated
7. Confirmed TB at time of death?	[1] Yes [0] No [2] Unknown	TBConfirmed
8. Where did the patient die?	[0] Home [1] Hospital [2] Clinic [3] Traditional healer's residence [4] Hospice [5] Other, please specify _____	DiedWhere OtherSpecify
9. Was the patient admitted since previous study visit?	[1] Yes [0] No [2] Unknown	Admitted

Patient Initials *First* *Middle* *Last*

	Visit 1	FU	FU	FU	
1. Patient on ARV treatment at present?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	ARVTreatment
2. Has the patient been exposed to ARV's in the past?	1 Yes 0 No				ARVExposed
2.1 Please specify which ARV's?		**Start date** mm yyyy	**End date** mm yyyy	**Continued**	
2.1.1 NVP - single dose NVP	1 Yes 0 No				
2.1.2 Monotherapy MonoTher	1 Yes 0 No			1 Yes	
2.1.3 Dualtherapy DualTher	1 Yes 0 No			1 Yes	
2.1.4 HAART Haart	1 Yes 0 No			1 Yes	
Please fill in the attached ARV form					
3. Please give estimated compliance with treatment.	%	%	%	%	Compliance
4. How many doses did you miss in the last 3 days.	N	N	N	N	Tablets
5. Were there any Adverse Events at this visit or since last study visit?	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	1 Yes 0 No	AENY
Please fill in attached Adverse Events page					

Adult Wellness
ARV CRF

ARVLog

ARV Log

Study ID | | | | | | | |

StudyDrug Dose Unit Visit ARVStartd/ARVStartm/ ARVStarty ARVStopd/ARVStopm/ ARVStopy ContEnd-Stud ReasChange

Study Drug*	Dose (p/d)	Unit	Visit	Date Started			Date Stopped			Cont at end of study	Reas for Change*
				dd	*mm*	*yy*	*dd*	*mm*	*yy*		
1.		☐ *mg/d* ☐ *ml/d*								☐	☐
2.		☐ *mg/d* ☐ *ml/d*								☐	☐
3.		☐ *mg/d* ☐ *ml/d*								☐	☐
4.		☐ *mg/d* ☐ *ml/d*								☐	☐
5.		☐ *mg/d* ☐ *ml/d*								☐	☐
6.		☐ *mg/d* ☐ *ml/d*								☐	☐
7.		☐ *mg/d* ☐ *ml/d*								☐	☐
8.		☐ *mg/d* ☐ *ml/d*								☐	☐
9.		☐ *mg/d* ☐ *ml/d*								☐	☐
10.		☐ *mg/d* ☐ *ml/d*								☐	☐
11.		☐ *mg/d* ☐ *ml/d*								☐	☐
12.		☐ *mg/d* ☐ *ml/d*								☐	☐
13.		☐ *mg/d* ☐ *ml/d*								☐	☐



If reason for change has been Ticked as "5", complete the AE Form.

**Refer to Codelist on the Information Page*

Current ARV Log

- *All study medications should be listed under "Study Drug".*
- *"Dose" should be entered as detailed as possible*
- *All study medications should have a "Start Date"*
- *If the Study Medication is ongoing/ continued at the time of the Visit, 'Date Stopped' should be left blank and the "Cont" tickbox should be entered.*
- *If the medication has been discontinued at a following visit, the "Cont" tickbox should be lined through, initialed and dated, and the "Date Stopped" should be entered.*
- *Please refer to the key below for the "Study Drug" and "Reason for Change":*

ARV Drug:

1. = Lopinavir + Ritonavir (Kaletra)
2. = Zidovudine (Retrovir)
3. = Didanosine (Videx)
4. = Efavirenz (Stocrin)
5. = Lamivudine (3TC, Epivir)
6. = Nelfinavir (Viracept)
7. = Nevirapine (Viramune)
8. = Ritonavir (Norvir)
9. = Saquinavir (Invirase, Fortovase)
10. = Stavudine (Zerit)
11. = Tenofovir (Vilread)
12. = Indinavir (Crixivan)
13. = Combivir (AZT, 3TC)
14. = Atazanavir (Zrivada)

Reason for Change:

1. = Virological failure
2. = Investigator initiated interruption
3. = Patient initiated interruption
4. = Pregnancy
5. = Drug Toxicity (AE related)
6. = Drug Toxicity (non-AE related)
7. = Dose change
8. = Tuberculosis
9. = Regimen change
10. = Withdrawal of consent
11. = Patient Lost to Follow-up
12. = Other

Adverse Events

Study ID | | | | | | |

Other That HIV related conditions - To be completed at each visit

	Adverse Event	Start date	End date	Continuous	Severity	Outcome	Serious
1		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
2		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
3		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
4		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
5		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
6		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
7		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
8		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
9		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
10		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
11		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
12		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
13		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No
14		dd mm yyyy	dd mm yyyy	1 Yes			1 Yes 0 No

Severity

1 = Grade 1 - Mild

2 = Grade 2 - Moderate

3 = Grade 3 - Severe

4 = Grade 4 - Severe

5 = Grade 5 - Death

Outcome

1 = Resolved

2 = Death

3 = Severity/frequency increased

4 = Continuing at end of study participation

Current Medicines and Adherence

TB Preventive Therapy

1. Provide date of third visit to Clinic. *(Treatment should start from 3rd study visit)* — dd mm yyyy — ThirdVd/Third-Vm/ThirdVy

2. Is patient on TB Preventive Therapy? 1 Yes 0 No — TBPT

2.1 Provide following information:

Start date of treatment (m1d/m1m/m1y)	Date of first medication dispensed (dd mm yyyy)	
m2d/m2m/m2y	Date of TBPT refill - month 2 (dd mm yyyy)	Number of doses missed in last 3 days. — m2missed
m3d/m3m/m3y	Date of TBPT refill - month 3 (dd mm yyyy)	Number of doses missed in last 3 days. — m3missed
m4d/m4m/m4y	Date of TBPT refill - month 4 (dd mm yyyy)	Number of doses missed in last 3 days — m4missed
m5d/m5m/m5y	Date of TBPT refill - month 5 (dd mm yyyy)	Number of doses missed in last 3 days. — m5missed
m6d/m6m/m6y	Date of TBPT refill - Month 6 (dd mm yyyy)	Number of doses missed in last 3 days3. — m6missed
Please provide end date of treatment	(dd mm yyyy)	endd/endm/endy

If patient stopped treatment, please give reason — TreatStopReas

Completed 6 months of TBPT	1 Yes 0 No
Side effects	1 Yes 0 No
Treatment Interrupter	1 Yes 0 No
Developed TB symptoms	1 Yes 0 No
Other, please specify _____	OtherReason