

**APPENDIX C\***

**Physical Examination Methodology**

\*Original forms were color coded; limited photocopy quality.

|             |   |   |   |   |   |   |   |   |   |                |           |           |           |           |          |          |          |          |          |          |          |          |          |   |  |  |  |  |  |  |  |  |  |
|-------------|---|---|---|---|---|---|---|---|---|----------------|-----------|-----------|-----------|-----------|----------|----------|----------|----------|----------|----------|----------|----------|----------|---|--|--|--|--|--|--|--|--|--|
| CASE NUMBER |   |   |   |   |   |   |   |   |   | NAME:          |           |           |           |           |          |          |          |          |          | GROUP #  |          |          |          |   |  |  |  |  |  |  |  |  |  |
|             |   |   |   |   |   |   |   |   |   | DATE OF BIRTH: |           |           |           |           |          |          |          |          |          |          |          |          |          |   |  |  |  |  |  |  |  |  |  |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | TODAY'S DATE   | MO DAY YR | JAN 30 85 | FEB 20 86 | MAR 10 87 | APR 9 88 | MAY 8 89 | JUN 7 90 | JUL 6 91 | AUG 5 92 | SEP 4 93 | OCT 3 94 | NOV 2 95 | DEC 1 96 |  |  |  |  |  |  |  |  |  |  |
| FORM AFHS-1 |   |   |   |   |   |   |   |   |   | HISTORY        |           |           |           |           |          |          |          |          |          |          |          |          |          |   |  |  |  |  |  |  |  |  |  |

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FAMILY HISTORY - PLEASE BLACKEN THE CIRCLE FOR ANY FAMILY MEMBER THAT HAS HAD ANY OF THE FOLLOWING

|                      |                     |                       |                       |                       |                       |                       |                       |
|----------------------|---------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| REVIEWER'S COMMENTS: | BLOOD RELATIVES →   | NONE                  | MOTHER                | FATHER                | SISTER                | BROTHER               | CHILD                 |
|                      | DIABETES            | <input type="radio"/> |
|                      | EPILEPSY            | <input type="radio"/> |
|                      | CANCER              | <input type="radio"/> |
|                      | HIGH BLOOD PRESSURE | <input type="radio"/> |
|                      | HEART DISEASE       | <input type="radio"/> |
|                      | STROKE              | <input type="radio"/> |
|                      | ALLERGY             | <input type="radio"/> |
|                      | STOMACH TROUBLE     | <input type="radio"/> |
|                      | NERVOUS TROUBLE     | <input type="radio"/> |
|                      | BLOOD DISEASE       | <input type="radio"/> |
|                      | DEFORMITIES         | <input type="radio"/> |
|                      | ARTHRITIS           | <input type="radio"/> |
|                      | OTHER FAMILIAL DIS. | <input type="radio"/> |
|                      | → PLEASE LIST HERE: |                       |                       |                       |                       |                       |                       |

CURRENT FAMILY STATUS

|  |                                       |                                     |   |                                    |   |
|--|---------------------------------------|-------------------------------------|---|------------------------------------|---|
| FATHER:  | LIVING-AGE <input type="checkbox"/>   | DEAD-AGE <input type="checkbox"/>   | CONDITION OF HEALTH? <input type="radio"/> EXCELLENT <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> POOR |                                    |   |
| MOTHER:  | LIVING-AGE <input type="checkbox"/>   | DEAD-AGE <input type="checkbox"/>   | CONDITION OF HEALTH? <input type="radio"/> EXCELLENT <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> POOR |                                    |   |
| BROTHERS:  | NUMBER <input type="checkbox"/>       | LIVING <input type="checkbox"/>     | DEAD <input type="checkbox"/>   | AGES <input type="text"/>          | CAUSES <input type="text"/>                 |
| SISTERS:   | NUMBER <input type="checkbox"/>       | LIVING <input type="checkbox"/>     | DEAD <input type="checkbox"/>   | AGES <input type="text"/>          | CAUSES <input type="text"/>                 |
| ARE YOU MARRIED? <input type="checkbox"/>  | NO. OF YEARS <input type="checkbox"/> | WIFE'S AGE <input type="checkbox"/> | HEALTH OF WIFE? <input type="radio"/> EXCELLENT <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> POOR      |                                    |   |
| IF WIFE IS DEAD, PLEASE GIVE AGE, YEAR, AND CAUSE OF DEATH: <input type="text"/> |                                       |                                     |   |                                    |   |
| CHILDREN:  | BOYS' AGES <input type="text"/>       | GIRLS' AGES <input type="text"/>    | ALL HEALTHY? <input type="checkbox"/>   | ANY DEAD? <input type="checkbox"/> | ANY BIRTH DEFECTS? <input type="checkbox"/> |

DO YOU HAVE ANY PHYSICAL OR NERVOUS COMPLAINTS?

YES  NO EXPLAIN:

DO YOU HAVE ANY ALLERGIES OR SEVERE REACTIONS TO MEDICINES, FOODS, PLANTS, CHEMICALS, ETC.?

YES  NO

PLEASE DESCRIBE:

**PERSONAL HISTORY**

YES NO

- SKIN TROUBLE
- ACNE
- EXCESS HAIR GROWTH
- OTHER SKIN TROUBLE

YES NO

- HEPATITIS
- WORMS
- COLITIS
- HEMORRHOIDS
- KIDNEY STONES
- KIDNEY TROUBLE
- BLADDER TROUBLE
- PROSTATE TROUBLE
- SYPHILIS
- GONORRHEA
- FAINTING
- FITS OR CONVULSIONS
- DEPRESSION
- NERVOUS BREAKDOWN
- PARALYSIS
- MUSCLE PAIN
- MUSCLE WEAKNESS
- NUMBNESS
- LOSS OF SENSATION
- LOSS OF SEX DRIVE
- RHEUMATOID ARTHRITIS
- SEVERE ARTHRITIS
- SYSTEMIC LUPUS ERYTHEMATOSIS

YES NO

- ARTHRITIS
- SCLERODERMA
- RHEUMATIC FEVER
- CANCER OR TUMOR
- VARICOSE VEINS
- PHLEBITIS
- HERNIA (RUPTURE)
- ANEMIA
- POLIO
- MUMPS
- MALARIA
- GOUT
- DIABETES
- MEASLES
- DYSENTERY

← BLACKEN THE  CIRCLE NEXT TO ANY OF THESE CONDITIONS THAT YOU NOW HAVE OR HAVE HAD IN THE PAST, OTHERWISE BLACKEN .

REVIEWER'S COMMENTS:

- CATARACTS
- TONSILLITIS
- SINUSITIS
- GOTTOR
- HAY FEVER
- ASTHMA
- BRONCHITIS
- PLEURISY
- PNEUMONIA
- TUBERCULOSIS
- HEART TROUBLE
- STOMACH TROUBLE
- ULCERS
- GALLSTONES
- JAUNDICE
- LIVER TROUBLE

LIST THE AVERAGE FOR EACH OF THE FOLLOWING DURING THE LAST 90 DAYS:

|                      | PER DAY                |                      |
|----------------------|------------------------|----------------------|
| <input type="text"/> | HOURS WORKED PER DAY   | <input type="text"/> |
| <input type="text"/> | HOURS SLEEP PER NIGHT  | <input type="text"/> |
| <input type="text"/> | DAYS WORKED PER WEEK   | <input type="text"/> |
| <input type="text"/> | DAYS VACATION PER YEAR | <input type="text"/> |
| <input type="text"/> | NUMBER CIGARETTES      | <input type="text"/> |
| <input type="text"/> | ALCOHOLIC DRINKS       | <input type="text"/> |
| <input type="text"/> | CUPS COFFEE            | <input type="text"/> |
| <input type="text"/> | CHEWING TOBACCO        | <input type="text"/> |
| <input type="text"/> | SNUFF                  | <input type="text"/> |

FOR THE PAST 90 DAYS OR MORE:

DID YOU TAKE REGULAR EXERCISE?

WHAT IS YOUR USUAL WEIGHT?  LBS

WHAT IS THE MOST YOU EVER WEIGHED?  LBS

AT WHAT AGE?

HAVE YOU RECENTLY LOST OR GAINED WEIGHT?

IF SO, HOW MUCH? (+/-)  LBS

**PAST HISTORY**

PLEASE LIST PREVIOUS OPERATIONS, INJURIES, AND SERIOUS ILLNESSES, INCLUDING THOSE INDICATED ABOVE

YEAR DESCRIPTION OF OPERATION, INJURY, OR SERIOUS ILLNESS

|                                  |                      |
|----------------------------------|----------------------|
| <input type="text"/>             | <input type="text"/> |
| <input type="text"/>             | <input type="text"/> |
| <b>DO NOT MARK IN THIS SPACE</b> |                      |
| <input type="text"/>             | <input type="text"/> |
| <input type="text"/>             | <input type="text"/> |

PLEASE BLACKEN THE CIRCLE IF YOU HAVE HAD REPEATED CASES OF ANY OF THE FOLLOWING IN THE PAST YEAR:

- PNEUMONIA
- KIDNEY INFECTIONS
- SKIN BOILS
- OTHER INFECTIONS

SPECIFY →

WHEN WAS YOUR LAST PHYSICAL EXAM? MO  YR

ANY ABNORMALITY FOUND? YES  NO

ARE YOU UNDER ANY MEDICAL TREATMENT NOW? YES  NO

DID YOU TAKE ANY MEDICATIONS OR TREATMENT NOW OR OCCASIONALLY?  YES  NO

PLEASE DESCRIBE:

YOUR PERSONAL PHYSICIAN

NAME

STREET ADDRESS

CITY, STATE, & ZIP





|   |  |                     |  |          |                                 |   |
|---|--|---------------------|--|----------|---------------------------------|---|
| <b>CASE NUMBER</b>                                |  |                     |  |          | <b>NAME OF PARTICIPANT</b>      |  |
|   |  |                     |  | <b>B</b> |                                 |   |
| PAGE <input type="text"/> OF <input type="text"/> |  | <b>FORM AFHS-2B</b> |  |          | <b>EXPOSURE HISTORY DETAILS</b> |   |

FOR EACH "YES" EXPOSURE AT THE END OF FORM AFHS-2A. PLEASE FILL OUT ONE OF THE FOLLOWING BLOCKS. USE ADDITIONAL SHEETS IF NECESSARY.

|  |  |        |  |         |                                   |        |     |                                   |
|--|--|--------|--|---------|-----------------------------------|--------|-----|-----------------------------------|
| TYPE OF EXPOSURE (COAL TAR, ETC.)                          |  |        |  |         | WAS EXPOSURE RECEIVED ON THE JOB? |        | YES | NO                                |
| IF ON-THE-JOB EXPOSURE. JOB TITLE                          |  |        |  |         |                                   |        |     |                                   |
| IF NOT ON-THE-JOB EXPOSURE. HOW EXPOSURE RECEIVED          |  |        |  |         |                                   |        |     |                                   |
| CHECK FREQUENCY OF EXPOSURE THAT BEST FITS YOUR EXPERIENCE |  |        |  |         |                                   |        |     |                                   |
| DAILY  |  | WEEKLY |  | MONTHLY |                                   | YEARLY |     | IN WHAT YEAR(S) WERE YOU EXPOSED? |

|  |  |        |  |         |                                   |        |     |                                   |
|--|--|--------|--|---------|-----------------------------------|--------|-----|-----------------------------------|
| TYPE OF EXPOSURE (COAL TAR, ETC.)                          |  |        |  |         | WAS EXPOSURE RECEIVED ON THE JOB? |        | YES | NO                                |
| IF ON-THE-JOB EXPOSURE. JOB TITLE                          |  |        |  |         |                                   |        |     |                                   |
| IF NOT ON-THE-JOB EXPOSURE. HOW EXPOSURE RECEIVED          |  |        |  |         |                                   |        |     |                                   |
| CHECK FREQUENCY OF EXPOSURE THAT BEST FITS YOUR EXPERIENCE |  |        |  |         |                                   |        |     |                                   |
| DAILY  |  | WEEKLY |  | MONTHLY |                                   | YEARLY |     | IN WHAT YEAR(S) WERE YOU EXPOSED? |

|  |  |        |  |         |                                   |        |     |                                   |
|--|--|--------|--|---------|-----------------------------------|--------|-----|-----------------------------------|
| TYPE OF EXPOSURE (COAL TAR, ETC.)                          |  |        |  |         | WAS EXPOSURE RECEIVED ON THE JOB? |        | YES | NO                                |
| IF ON-THE-JOB EXPOSURE. JOB TITLE                          |  |        |  |         |                                   |        |     |                                   |
| IF NOT ON-THE-JOB EXPOSURE. HOW EXPOSURE RECEIVED          |  |        |  |         |                                   |        |     |                                   |
| CHECK FREQUENCY OF EXPOSURE THAT BEST FITS YOUR EXPERIENCE |  |        |  |         |                                   |        |     |                                   |
| DAILY  |  | WEEKLY |  | MONTHLY |                                   | YEARLY |     | IN WHAT YEAR(S) WERE YOU EXPOSED? |

|  |  |        |  |         |                                   |        |     |                                   |
|--|--|--------|--|---------|-----------------------------------|--------|-----|-----------------------------------|
| TYPE OF EXPOSURE (COAL TAR, ETC.)                          |  |        |  |         | WAS EXPOSURE RECEIVED ON THE JOB? |        | YES | NO                                |
| IF ON-THE-JOB EXPOSURE. JOB TITLE                          |  |        |  |         |                                   |        |     |                                   |
| IF NOT ON-THE-JOB EXPOSURE. HOW EXPOSURE RECEIVED          |  |        |  |         |                                   |        |     |                                   |
| CHECK FREQUENCY OF EXPOSURE THAT BEST FITS YOUR EXPERIENCE |  |        |  |         |                                   |        |     |                                   |
| DAILY  |  | WEEKLY |  | MONTHLY |                                   | YEARLY |     | IN WHAT YEAR(S) WERE YOU EXPOSED? |

|                    |   |   |   |   |   |   |   |   |   |                       |                  |     |     |     |     |     |     |     |     |     |     |                |     |   |  |  |  |  |  |  |  |  |  |  |  |
|--------------------|---|---|---|---|---|---|---|---|---|-----------------------|------------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|----------------|-----|---|--|--|--|--|--|--|--|--|--|--|--|
| <b>CASE NUMBER</b> |   |   |   |   |   |   |   |   |   | <b>NAME:</b>          |                  |     |     |     |     |     |     |     |     |     |     | <b>GROUP #</b> |     |   |  |  |  |  |  |  |  |  |  |  |  |
|                    |   |   |   |   |   |   |   |   |   | <b>DATE OF BIRTH:</b> |                  |     |     |     |     |     |     |     |     |     |     |                |     |   |  |  |  |  |  |  |  |  |  |  |  |
| 0                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | <b>TODAY'S DATE</b>   | <b>MO DAY YR</b> | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT | NOV            | DEC |  |  |  |  |  |  |  |  |  |  |  |  |
| 0                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                       |                  | 30  | 20  | 10  | 9   | 8   | 7   | 6   | 5   | 4   | 3   | 2              | 1   |   |  |  |  |  |  |  |  |  |  |  |  |
| 0                  | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                       |                  | 85  | 86  | 87  | 88  | 89  | 90  | 91  | 92  | 93  | 94  | 96             | 96  |   |  |  |  |  |  |  |  |  |  |  |  |

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**GENERAL APPEARANCE**

|                 | APPEARANCE VS STATED AGE | APPEARANCE OF ILLNESS OR DISTRESS | HAIR DISTRIBUTION |
|-----------------|--------------------------|-----------------------------------|-------------------|
| WELL NOURISHED  | YOUNGER THAN             | YES                               | NORMAL            |
| OBESE           | OLDER THAN               |                                   |                   |
| UNDER-NOURISHED | SAME AS                  | NO                                | ABNORMAL          |

DESCRIBE ANY ABNORMAL HAIR DISTRIBUTION:

NOTE: FILL IN VITAL SIGNS WITH "0" IF REFUSED.

**VITAL SIGNS**

| HEIGHT<br>CM | WEIGHT<br>(UNPRESSURE)<br>KG | TEMPERATURE<br>ORAL<br>°F | SITTING BLOOD PRESSURE<br>(NONDOMINANT ARM, HEART LEVEL) |           | PULSE<br>RATE | VPM<br>PER<br>MINUTE | PULSE IS:<br>REGULAR<br>IRREGULAR<br>IRREGULARLY IRREGULAR |
|--------------|------------------------------|---------------------------|--|-----------|---------------|----------------------|--|
|              |                              |                           | SYSTOLIC   | DIASTOLIC |               |                      |  |
| 0 0 0        | 20 0 0                       | 37 0 0                    | 0 0 0  | 0 0 0     | 0 0 0         | 0 0                  | DESCRIBE ANY IRREGULARITIES:<br>Y N COMMENT                |
| 1 1 1        | 20 1 1                       | 38 1 1                    | 1 1 1  | 1 1 1     | 1 1 1         | 1 1                  |  |
| 2 2 2        | 20 2 2                       | 39 2 2                    | 2 2 2  | 2 2 2     | 2 2 2         | 2 2                  |  |
| 3 3 3        | 20 3 3                       | 40 3 3                    | 3 3 3  | 3 3 3     | 3 3 3         | 3 3                  |  |
| 4 4 4        | 20 4 4                       | 41 4 4                    | 4 4 4  | 4 4 4     | 4 4 4         | 4 4                  |  |
| 5 5 5        | 20 5 5                       | 42 5 5                    | 5 5 5  | 5 5 5     | 5 5 5         | 5 5                  |  |
| 6 6 6        | 20 6 6                       | 43 6 6                    | 6 6 6  | 6 6 6     | 6 6 6         | 6 6                  |  |
| 7 7 7        | 20 7 7                       | 44 7 7                    | 7 7 7  | 7 7 7     | 7 7 7         | 7 7                  |  |
| 8 8 8        | 20 8 8                       | 45 8 8                    | 8 8 8  | 8 8 8     | 8 8 8         | 8 8                  |  |
| 9 9 9        | 20 9 9                       | 46 9 9                    | 9 9 9  | 9 9 9     | 9 9 9         | 9 9                  |  |

**EYES**

|                                | FUNDUSCOPIC |    |                  |    | EXTERNAL |             |   |   |                              |
|--------------------------------|-------------|----|------------------|----|----------|-------------|---|---|------------------------------|
|                                | YES         | NO | YES              | NO | YES      | NO          |   |   |                              |
| <input type="radio"/> NORMAL   | Y           | N  | ↑ LIGHT REFLEX   | Y  | N        | HEMORRHAGES | Y | N | ARCUS SENILIS PRESENT        |
| <input type="radio"/> ABNORMAL | Y           | N  | A-V NICKING      | Y  | N        | EXUDATES    | Y | N | ABNORMAL OCULAR PIGMENTATION |
| <input type="radio"/> REFUSED  | Y           | N  | ARTERIOLAR SPASM | Y  | N        | DISK PALLOR |   |   |                              |
|                                | Y           | N  | PAPILLEDEMA      | Y  | N        | ↑ CUPPING   |   |   |                              |

DESCRIBE VASCULAR LESIONS, HEMORRHAGES, EXUDATES, OR PAPILLEDEMA:

**ENT**

NORMAL  
 ABNORMAL  
 REFUSED

|  |     |    |                                |
|--|-----|----|--------------------------------|
|  | YES | NO |                                |
|  | Y   | N  | RIGHT TYMPANIC MEMBRANE INTACT |
|  | Y   | N  | LEFT TYMPANIC MEMBRANE INTACT  |
|  | Y   | N  | NASAL ULCERATIONS              |
|  | Y   | N  | COMMENT                        |

DESCRIBE ABNORMALITY:

**NECK**

|   |   |  |  |   |             |   |
|---|---|--|--|---|-------------|---|
| <input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL<br><input type="radio"/> REFUSED | <b>THYROID GLAND</b>  |  |  |   | <b>LEFT</b> | <b>RIGHT</b>  |
|   | <input checked="" type="radio"/> Y<br><input type="radio"/> N | <input type="radio"/> PALPABLE<br><input type="radio"/> ENLARGED | <input type="radio"/> Y<br><input type="radio"/> N | <input type="radio"/> NODULES<br><input type="radio"/> TENDERNESS |             | PAROTID GLAND ENLARGEMENT<br>CAROTID PULSE ABSENT<br>CAROTID BRUIT PRESENT<br>Y N COMMENT |

DESCRIBE ABNORMALITY:

**THORAX AND LUNGS**

NORMAL  
 ABNORMAL  
 REFUSED

| <input type="radio"/> YES<br><input type="radio"/> NO | <input type="radio"/> ASYMMETRICAL EXPANSION<br><input type="radio"/> HYPERRESONANCE<br><input type="radio"/> DULLNESS<br><input type="radio"/> WHEEZES<br><input type="radio"/> RALES (NOTE LOCATION IN BOX BELOW) | <b>CHEST CIRCUMFERENCE (CM) AT NIPPLE LEVEL</b><br><table border="1"> <thead> <tr> <th colspan="2">EXPIRATION</th> <th colspan="2">INSPIRATION</th> </tr> <tr> <th>1</th> <th>2</th> <th>1</th> <th>2</th> </tr> </thead> <tbody> <tr><td>0</td><td>0</td><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td><td>9</td><td>9</td></tr> </tbody> </table> | EXPIRATION |  | INSPIRATION |  | 1 | 2 | 1 | 2 | 0 | 0 | 0 | 0 | 1 | 1 | 1 | 1 | 2 | 2 | 2 | 2 | 3 | 3 | 3 | 3 | 4 | 4 | 4 | 4 | 5 | 5 | 5 | 5 | 6 | 6 | 6 | 6 | 7 | 7 | 7 | 7 | 8 | 8 | 8 | 8 | 9 | 9 | 9 | 9 |
|---|---|---|------------|--|-------------|--|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EXPIRATION  |   | INSPIRATION   |            |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 1   | 2   | 1   | 2          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 0   | 0   | 0   | 0          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 1   | 1   | 1   | 1          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 2   | 2   | 2   | 2          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 3   | 3   | 3   | 3          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 4   | 4   | 4   | 4          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 5   | 5   | 5   | 5          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 6   | 6   | 6   | 6          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 7   | 7   | 7   | 7          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 8   | 8   | 8   | 8          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |
| 9   | 9   | 9   | 9          |  |             |  |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |   |

DESCRIBE ABNORMALITY:

Y  N COMMENT

**HEART**

|   |  |  |  |
|---|--|--|--|
| <input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL<br><input type="radio"/> REFUSED | HEART SOUNDS NORMAL<br>DISPLACEMENT OF APICAL IMPULSE<br>PRECORDIAL THRUST | YES NO<br><input type="radio"/> <input type="radio"/><br><input type="radio"/> <input type="radio"/> | <b>ABNORMAL HEART SOUND(S)</b><br>NO N N N N<br>S1 S2 S3 S4<br>YES Y Y Y Y |
|---|--|--|--|

|               |           |                   |                 |             |               |             |
|---------------|-----------|-------------------|-----------------|-------------|---------------|-------------|
| <b>MURMUR</b> |           | <b>CHEST AREA</b> |                 |             |               |             |
| NO            | SYSTOLIC  | AORTIC<br>Y N     | PULMONIC<br>Y N | APEX<br>Y N | MITRAL<br>Y N |             |
| YES           | DIASTOLIC | Y N               | Y N             | Y N         | Y N           | Y N COMMENT |

DESCRIBE ANY ENLARGEMENT, IRREGULARITY OF RATE, MURMUR, OR THRILL:

|   |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
|---|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| CASE NUMBER   |  |  |  |  |  |  |  |  |  | NAME: _____   |  |  |  |  |  |  |  |  |  |  |  | GROUP # _____   |  |  |  |  |  |  |  |  |  |  |  |
|   |  |  |  |  |  |  |  |  |  | DATE OF BIRTH:  |  |  |  |  |  |  |  |  |  |  |  |   |  |  |  |  |  |  |  |  |  |  |  |
| <input type="radio"/> 0 <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7 <input type="radio"/> 8 <input type="radio"/> 9 |  |  |  |  |  |  |  |  |  | TODAY'S DATE<br>MO DAY YR<br>JAN 30 85 FEB 20 86 MAR 10 87 APR 9 88 MAY 8 89 JUN 7 90 JUL 6 91 AUG 5 92 SEP 4 93 OCT 3 94 NOV 2 95 DEC 1 96 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| VERSION 1.0 JRW:SCF 585   |  |  |  |  |  |  |  |  |  | FORM AFHS 3B  |  |  |  |  |  |  |  |  |  |  |  | PHYSICAL EXAMINATION (CONTINUED)  |  |  |  |  |  |  |  |  |  |  |  |

**ABDOMEN**

|   |                         |                         |   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
|---|-------------------------|-------------------------|---|---|-----|-----|----|----|----|---|--|--|--|--|------------|-------------------|--|----|-----|-----|-----|----|----|----|----|----|----|----|----|----|---|---|---|---|---|---|---|---|---|---|
| <input type="radio"/> NORMAL<br><br><input type="radio"/> ABNORMAL<br><br><input type="radio"/> REFUSED | YES                     | NO                      |   | CM  |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
|   | <input type="radio"/> Y | <input type="radio"/> N | HEPATOMEGALY  | <table border="1"> <tr> <td colspan="3">WAIST MEASUREMENT</td> <td>100</td><td>110</td><td>120</td> </tr> <tr> <td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table> |     |     |    |    |    |   |  |  |  |  |            | WAIST MEASUREMENT |  |    | 100 | 110 | 120 | 10 | 20 | 30 | 40 | 50 | 60 | 70 | 80 | 90 | 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |
|   | WAIST MEASUREMENT       |                         |   | 100   | 110 | 120 |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
|   | 10                      | 20                      | 30  | 40  | 50  | 60  | 70 | 80 | 90 |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
|   | 0                       | 1                       | 2   | 3   | 4   | 5   | 6  | 7  | 8  | 9 |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| <input type="radio"/> Y   | <input type="radio"/> N | SPLENOMEGALY            | <table border="1"> <tr> <td colspan="3">LIVER SPAN</td> <td>10</td><td>20</td><td>30</td> </tr> <tr> <td>10</td><td>20</td><td>30</td> </tr> <tr> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table> |   |     |     |    |    |    |   |  |  |  |  | LIVER SPAN |                   |  | 10 | 20  | 30  | 10  | 20 | 30 | 0  | 1  | 2  | 3  | 4  | 5  | 6  | 7 | 8 | 9 |   |   |   |   |   |   |   |
| LIVER SPAN  |                         |                         | 10  | 20  | 30  |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| 10  | 20                      | 30                      |   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| 0   | 1                       | 2                       | 3   | 4   | 5   | 6   | 7  | 8  | 9  |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| <input type="radio"/> Y   | <input type="radio"/> N | TENDERNESS LIVER        | Y N COMMENT   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| <input type="radio"/> Y   | <input type="radio"/> N | TENDERNESS SPLEEN       |   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| <input type="radio"/> Y   | <input type="radio"/> N | OTHER TENDERNESS        |   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |
| <input type="radio"/> Y   | <input type="radio"/> N | OTHER MASS              |   |   |     |     |    |    |    |   |  |  |  |  |            |                   |  |    |     |     |     |    |    |    |    |    |    |    |    |    |   |   |   |   |   |   |   |   |   |   |

DESCRIBE ABNORMALITY:

**EXTREMITIES**

|   |                         |                         |                                |                         |                         |                            |
|---|-------------------------|-------------------------|--------------------------------|-------------------------|-------------------------|----------------------------|
| <input type="radio"/> NORMAL<br><br><input type="radio"/> ABNORMAL<br><br><input type="radio"/> REFUSED | YES                     | NO                      |                                | YES                     | NO                      |                            |
|   | <input type="radio"/> Y | <input type="radio"/> N | PITTING EDEMA                  | <input type="radio"/> Y | <input type="radio"/> N | CLUBBING OF NAILS          |
|   | <input type="radio"/> Y | <input type="radio"/> N | NON-PITTING EDEMA              | <input type="radio"/> Y | <input type="radio"/> N | VARICOSITIES               |
|   | <input type="radio"/> Y | <input type="radio"/> N | ABSENCE (SPECIFY IN BOX BELOW) | <input type="radio"/> Y | <input type="radio"/> N | LOSS OF HAIR ON TOES RIGHT |
|   | <input type="radio"/> Y | <input type="radio"/> N |                                | <input type="radio"/> Y | <input type="radio"/> N | LOSS OF HAIR ON TOES LEFT  |

DESCRIBE EDEMA, SIGNS OF VASCULAR INSUFFICIENCY, OR ABSENCE OF PART OR ALL OF EXTREMITY:

**PERIPHERAL PULSES**

|                  |                       |                       |                       |                       |
|------------------|-----------------------|-----------------------|-----------------------|-----------------------|
|                  | NORMAL                | DIMINISHED            | ABSENT                | REFUSED               |
| RADIAL           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| FEMORAL          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| POPLITEAL        | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| DORSALIS PEDIS   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| POSTERIOR TIBIAL | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

COMMENTS:  Y  N

| MUSCULOSKELETAL   |                       |                       |                      |  |                       |                           |
|---|-----------------------|-----------------------|----------------------|--|-----------------------|---------------------------|
| <input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL<br><input type="radio"/> REFUSED | MUSCLES               |                       |                      | SPINE  |                       |                           |
|   | PRESENT               | ABSENT                |                      | PRESENT  | ABSENT                |                           |
| <b>STRAIGHT LEG RAISING</b><br><input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL   | <input type="radio"/> | <input type="radio"/> | WEAKNESS             | <input type="radio"/>  | <input type="radio"/> | SCOLIOSIS                 |
|   | <input type="radio"/> | <input type="radio"/> | TENDERNESS           | <input type="radio"/>  | <input type="radio"/> | KYPHOSIS                  |
|   | <input type="radio"/> | <input type="radio"/> | ATROPHY              | <input type="radio"/>  | <input type="radio"/> | PELVIC TILT               |
|   | <input type="radio"/> | <input type="radio"/> | ABNORMAL CONSISTENCY | <input type="radio"/>  | <input type="radio"/> | DECREASED RANGE OF MOTION |
|   |                       |                       |                      | <input type="radio"/>  | <input type="radio"/> | TENDERNESS                |
| <input type="radio"/> <input type="radio"/> COMMENT   |                       |                       |                      | <b>TENDERNESS LEVEL</b><br><input type="radio"/> CERVICAL <input type="radio"/> THORACIC <input type="radio"/> LUMBAR <input type="radio"/> SACRAL |                       |                           |
| COMMENTS:   |                       |                       |                      |  |                       |                           |

| GENITOURINARY/RECTAL/HERNIA  |   |   |   |   |        |                       |                       |                       |
|--|---|---|---|---|--------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL<br><input type="radio"/> REFUSED<br><input type="radio"/> <input type="radio"/> COMMENT | YES NO                                      |   | YES NO                                      |   | TESTES |                       |                       |                       |
|  | <input type="radio"/> <input type="radio"/> | NORM.  | ABS.                  | ENGL.                 | ATROPH.               |
|  | <input type="radio"/> <input type="radio"/> | LEFT   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|  | <input type="radio"/> <input type="radio"/> | RIGHT  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|  |   |   |   | 0 1 2 3 4 5 6 7 8 9<br>(DIAMETER-CM)        |        |                       |                       |                       |
| COMMENTS:  |   |   |   |   |        |                       |                       |                       |

| LYMPH NODES   |                 |                       |                       |                       |                       |                       |                       |
|---|-----------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| <input type="radio"/> NORMAL<br><input type="radio"/> ABNORMAL<br><input type="radio"/> REFUSED |                 | NON PALPABLE          | ENLARGED              | TENDER                | HARD                  | FIXED                 | CONFLUENT             |
|   |                 |                       | CERVICAL              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
|   | OCCIPITAL       | <input type="radio"/> |
|   | SUPRACLAVICULAR | <input type="radio"/> |
|   | AXILLARY        | <input type="radio"/> |
|   | EPITROCHLEAR    | <input type="radio"/> |
|   | INGUINAL        | <input type="radio"/> |
|   | FEMORAL         | <input type="radio"/> |

| OTHER TESTS ORDERED                                 |  |
|---|--|
| <input type="radio"/> YES                           |  |
| <input type="radio"/> NO                            |  |
| DESCRIBE:   |  |
| <input type="radio"/> <input type="radio"/> COMMENT |  |

PRINTED NAME OF EXAMINING PHYSICIAN

SIGNATURE











|             |   |   |   |   |   |   |   |   |   |                 |     |     |     |     |     |     |     |     |     |     |     |   |  |  |  |  |  |  |  |  |  |  |  |     |     |
|-------------|---|---|---|---|---|---|---|---|---|-----------------|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|-----|---|--|--|--|--|--|--|--|--|--|--|--|-----|-----|
| CASE NUMBER |   |   |   |   |   |   |   |   |   | NAME: _____     |     |     |     |     |     |     |     |     |     |     |     | GROUP # _____   |  |  |  |  |  |  |  |  |  |  |  |     |     |
|             |   |   |   |   |   |   |   |   |   | DATE OF BIRTH:  |     |     |     |     |     |     |     |     |     |     |     |  |  |  |  |  |  |  |  |  |  |  |  |     |     |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | TODAY'S<br>DATE | MO  | JAN | FEB | MAR | APR | MAY | JUN | JUL | AUG | SEP | OCT |   |  |  |  |  |  |  |  |  |  |  |  | NOV | DEC |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                 | DAY | 30  | 20  | 10  | 9   | 8   | 7   | 6   | 5   | 4   | 3   |   |  |  |  |  |  |  |  |  |  |  |  | 2   | 1   |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | YR              | 86  | 88  | 87  | 88  | 89  | 90  | 91  | 92  | 93  | 94  | 95  |   |  |  |  |  |  |  |  |  |  |  |  | 96  |     |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 |                 |     |     |     |     |     |     |     |     |     |     |     |   |  |  |  |  |  |  |  |  |  |  |  |     |     |
| 0           | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | FORM AFHS 8     |     |     |     |     |     |     |     |     |     |     |     | VIETNAM COMBAT INDEX  |  |  |  |  |  |  |  |  |  |  |  |     |     |

VERSION 1.0 JRW:SCF 585

**INSTRUCTIONS**

INSTRUCTIONS ARE INCLUDED WITH EACH QUESTION. BELOW IS AN EXAMPLE OF THE CORRECT WAY TO ANSWER EACH QUESTION.

EXAMPLE: DO YOU PLAN TO DO ANY OF THE FOLLOWING NEXT WEEK? (PLEASE BLACKEN EITHER "YES" OR "NO")

YES NO

- N VISIT A RELATIVE
- GO TO A MUSEUM
- N GO TO A MOVIE

(I WILL VISIT A RELATIVE AND GO TO A MOVIE NEXT WEEK)

**AIRCRAFT**

PLEASE INDICATE WHETHER YOU SERVED OR FLEW IN ANY OF THE FOLLOWING AIRCRAFT WHILE IN VIETNAM: (DO NOT INCLUDE TRANSPORTATION TO OR FROM VIETNAM)

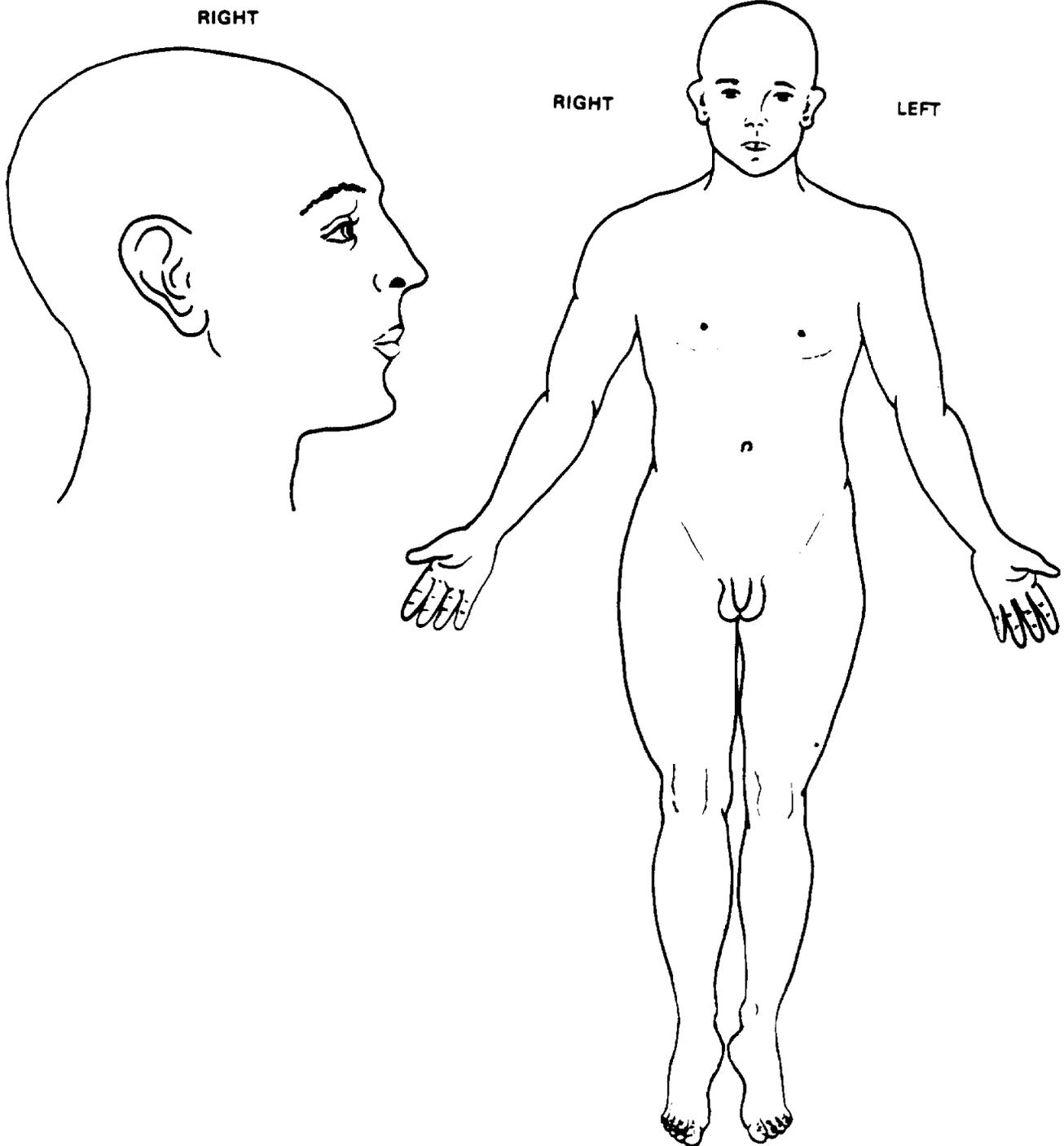
|                                      |                          |                         |                         |                         |                         |                         |
|--------------------------------------|--------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|
| WERE YOU EVER A<br>CREW MEMBER?      | YES                      | NO                      | YES                     | NO                      | YES                     | NO                      |
|                                      | <input type="radio"/> Y  | <input type="radio"/> N | <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> Y | <input type="radio"/> N |
|                                      |                          | F-4                     |                         | C-7                     |                         | C-130 (GUNSHIP)         |
|                                      |                          | F-5                     |                         | C-54                    |                         | HELICOPTER GUNSHIP      |
|                                      |                          | F-105                   |                         | C-118                   |                         | OTHER AIRCRAFT          |
| <input checked="" type="radio"/> YES | <input type="radio"/> NO |                         | B-52                    |                         | C-123                   | SPECIFY                 |
|                                      |                          |                         | B-66                    |                         | C-130                   |                         |

**EXPERIENCES**

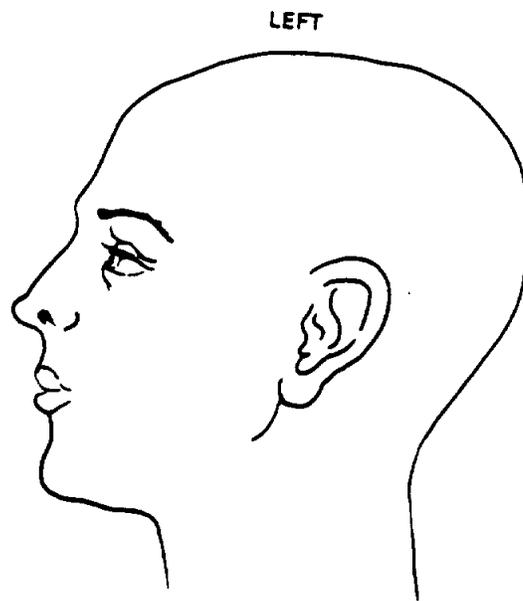
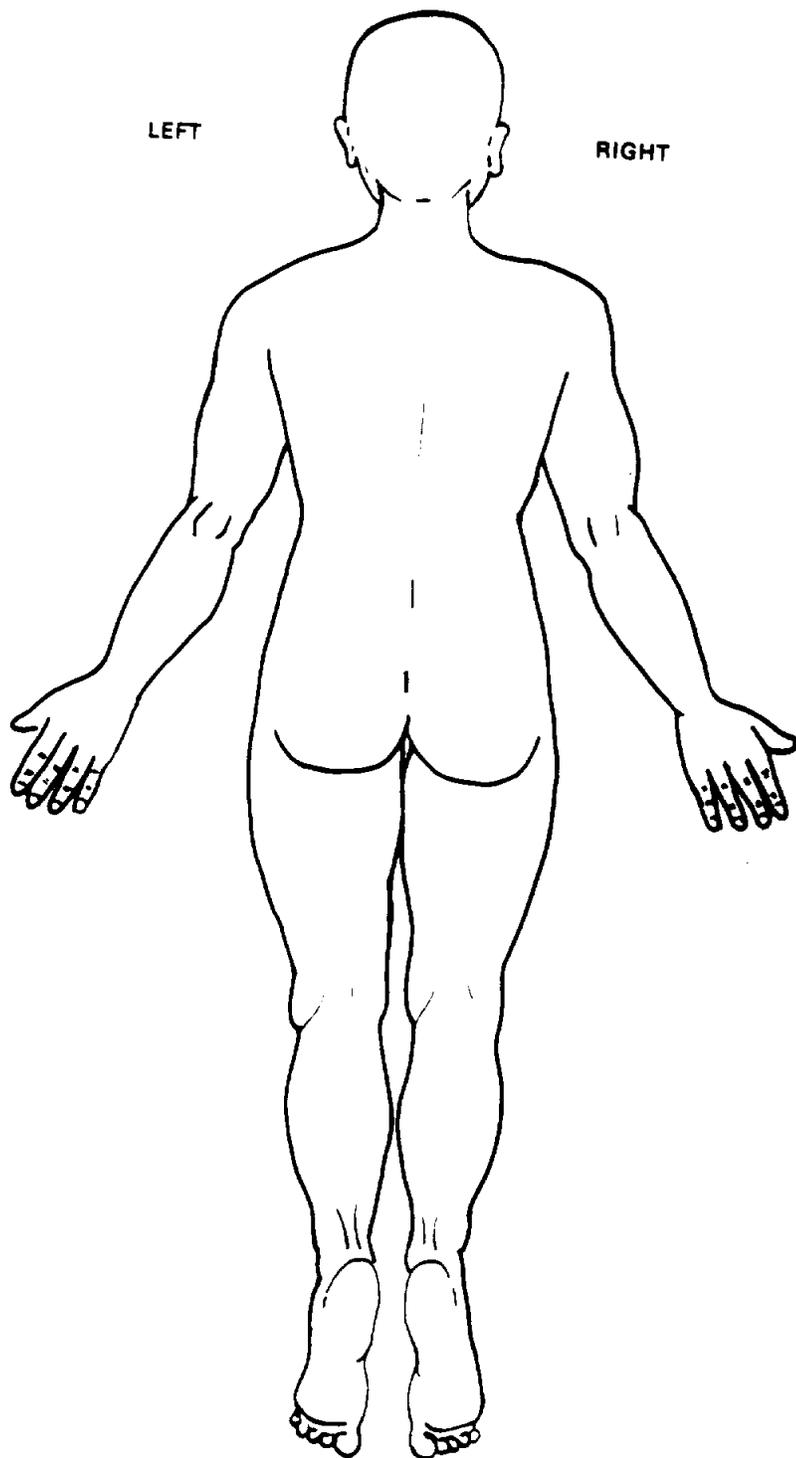
BELOW IS A LIST OF DIFFERENT COMBAT ROLES AND FLYING EXPERIENCES THAT AIR FORCE PERSONNEL HAD DURING THE VIETNAM WAR. FOR EACH STATEMENT, PLEASE BLACKEN THE "YES" CIRCLE IF YOU HAD THAT EXPERIENCE DURING THE VIETNAM WAR OR THE "NO" CIRCLE IF YOU DID NOT. PLEASE BLACKEN EITHER "YES" OR "NO" FOR EACH EXPERIENCE.

|   |   |
|---|---|
| YES NO  | YES NO  |
| <input checked="" type="radio"/> RECEIVED COMBAT PAY  | <input type="radio"/> FLEW IN AN AIRCRAFT THAT RECEIVED BATTLE DAMAGE                 |
| <input type="radio"/> CRASH LANDED, BAILED OUT, OR SHOT DOWN  | <input type="radio"/> RECEIVED INCOMING ARTILLERY OR ROCKET FIRE AT HOME BASE OR CAMP |
| <input type="radio"/> RECEIVED SNIPER OR SAPPER FIRE IN OR AROUND BASE  | <input type="radio"/> ENCOUNTERED MINES OR BOOBY TRAPS                                |
| <input type="radio"/> MOVED KILLED OR WOUNDED PERSONNEL   | <input type="radio"/> KILLED VC OR NVA IN STRAFING OR BOMBING RUNS                    |
| <input type="radio"/> SERVED AS A FORWARD AIR CONTROLLER (FAC)  | <input type="radio"/> WOUNDED   |
| <input type="radio"/> FLEW IN THE SAME AIRCRAFT WHEN FELLOW CREWMEMBER WAS WOUNDED OR KILLED                          | <input type="radio"/> HAD A CLOSE FRIEND KILLED IN ACTION                             |
| <input type="radio"/> FLEW IN THE SAME FORMATION OR ON THE SAME SORTIE WHEN A FELLOW CREWMEMBER WAS WOUNDED OR KILLED | <input type="radio"/> ENGAGED VC OR NVA IN A FIREFIGHT                                |
|   | <input type="radio"/> CAPTURED BY THE ENEMY   |

|                           |  |  |  |          |                            |             |              |           |   |
|---------------------------|--|--|--|----------|----------------------------|-------------|--------------|-----------|---|
| <b>CASE NUMBER</b>        |  |  |  |          | <b>NAME OF PARTICIPANT</b> | <b>LAST</b> | <b>FIRST</b> | <b>MI</b> |  |
|                           |  |  |  | <b>B</b> |                            |             |              |           |   |
| <b>ATTACHMENT TO FORM</b> |  |  |  |          | <b>FORM AFHS-9</b>         |             |              |           | <b>ANATOMICAL CHART</b>   |
| AFHS. _____               |  |  |  |          |                            |             |              |           |   |



(OVER)



PRINTED NAME OF EXAMINING PHYSICIAN

|           |      |
|-----------|------|
| SIGNATURE | DATE |
|-----------|------|

|                           |  |    |     |          |                                       |       |    |   |
|---------------------------|--|----|-----|----------|---------------------------------------|-------|----|---|
| <b>CASE NUMBER</b>        |  |    |     |          | <b>NAME OF PARTICIPANT</b>            |       |    |  |
|                           |  |    |     | <b>B</b> | LAST                                  | FIRST | MI |   |
| DATE ECG RECORDED         |  | MO | DAY | YR       | FORM AFHS-10 ELECTROCARDIOGRAM REPORT |       |    |   |
| ECG TECHNICIAN (INITIALS) |  |    |     |          |                                       |       |    |   |

| 12-LEAD SCALAR ELECTROCARDIOGRAM |                             |           |
|----------------------------------|-----------------------------|-----------|
|                                  | NORMAL                      | COMMENTS: |
|                                  | ABNORMAL                    |           |
|                                  | RBBB                        |           |
|                                  | LBBB                        |           |
|                                  | NON-SPECIFIC T-WAVE CHANGES |           |
|                                  | TACHYCARDIA                 |           |
|                                  | BRADYCARDIA                 |           |
|                                  | ARRHYTHMIA                  |           |
|                                  |                             |           |

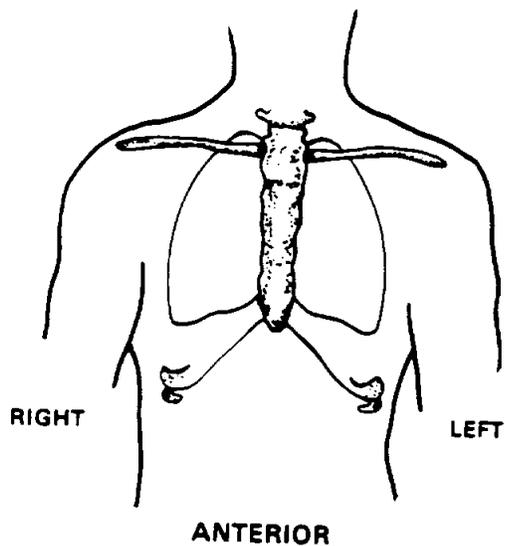
PARTICIPANT COMPLIANCE WITH 4-HOUR ABSTINENCE: YES \_\_\_\_\_ No \_\_\_\_\_

| RHYTHM STRIP                  |
|-------------------------------|
| INTERPRETATION OF ARRHYTHMIA: |

PRINTED NAME OF CARDIOLOGIST

|           |      |
|-----------|------|
| SIGNATURE | DATE |
|-----------|------|

|                                    |  |    |          |                            |                     |    |   |                                   |
|------------------------------------|--|----|----------|----------------------------|---------------------|----|---|-----------------------------------|
| <b>CASE NUMBER</b>                 |  |    |          | <b>NAME OF PARTICIPANT</b> |                     |    |  |                                   |
|                                    |  |    | <b>B</b> | LAST                       | FIRST               | MI |   |                                   |
| <b>DATE OF X-RAY</b>               |  | MO | DAY      | YR                         | <b>FORM AFHS-11</b> |    |   | <b>PA CHEST X-RAY EXAMINATION</b> |
| <b>X-RAY TECHNICIAN (INITIALS)</b> |  |    |          |                            |                     |    |   |                                   |



PLEASE MARK THE LOCATION OF ANY SUSPECTED ABNORMALITY(IES) WITH AN ENCIRCLED NUMBER AND DESCRIBE BELOW.

|  |   |                          |
|--|---|--------------------------|
| <b>INTERPRETATION OF PA CHEST FILM</b> |   |                          |
| <input type="checkbox"/>               | <b>NORMAL</b>   | <input type="checkbox"/> |
| <input type="checkbox"/>               |  | <b>ABNORMAL</b>          |
| <b>COMMENTS:</b>                       |   |                          |
|  |   |                          |

|                                    |
|------------------------------------|
| <b>PRINTED NAME OF RADIOLOGIST</b> |
|------------------------------------|

|                  |             |
|------------------|-------------|
| <b>SIGNATURE</b> | <b>DATE</b> |
|------------------|-------------|

|                                       |  |  |  |           |                            |           |   |   |              |           |
|---------------------------------------|--|--|--|-----------|----------------------------|-----------|---|---|--------------|-----------|
| <b>CASE NUMBER</b>                    |  |  |  |           | <b>NAME OF PARTICIPANT</b> |           |   |  |              |           |
|                                       |  |  |  | <b>B</b>  | <b>LAST</b>                |           |   |   | <b>FIRST</b> | <b>MI</b> |
| <b>DATE OF ANTIGEN ADMINISTRATION</b> |  |  |  | <b>MO</b> | <b>DAY</b>                 | <b>YR</b> | <b>FORM AFHS-12</b> <b>DELAYED SKIN TESTS</b> |   |              |           |
| <b>TIME OF ANTIGEN ADMINISTRATION</b> |  |  |  |           |                            |           |   |   |              |           |
| <b>ADMINISTERED BY (INITIALS)</b>     |  |  |  |           |                            |           |   |   |              |           |

**RESULTS**

E = ERYTHEMA, MEASURED IN mm  
I = INDURATION, MEASURED IN mm

| ANTIGEN:                              |  | 24-HOUR READING | 48-HOUR READING |
|---------------------------------------|--|-----------------|-----------------|
| CANDIDA ALBICANS                      | 1:1000 W/V   |                 |                 |
| MUMPS                                 | 2 CFU  |                 |                 |
| TRICHOPHYTON                          | 1:1000 W/V   |                 |                 |
| STAPH-PHAGE-LYSATE                    | STAPH=6 TO 9 x 10 <sup>4</sup> CFU<br>PHAGE=0.5 TO 5 x 10 <sup>7</sup> PFU |                 |                 |
| TIME OF DAY THAT SKIN TESTS WERE READ |  |                 |                 |
| SKIN TESTS READ BY (INITIALS)         |  |                 |                 |

|   |     |    |         |
|---|-----|----|---------|
| IS PARTICIPANT ON SYSTEMIC CORTICOSTEROIDS OR IMMUNOSUPPRESSANTS? | YES | NO | DOSAGE: |
|---|-----|----|---------|

**COMMENTS:**

**PRINTED NAME OF REVIEWER**

|                  |             |
|------------------|-------------|
| <b>SIGNATURE</b> | <b>DATE</b> |
|                  |             |



