

APPENDIX C

Physical Examination

1992 Examiner's Handbook and Physical Examination Forms

AIR FORCE HEALTH STUDY
EXAMINER'S HANDBOOK - 1992

6 January 1992

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A. General Instructions

The Air Force Health Study is a multiyear effort to determine whether or not Air Force personnel who were engaged in the aerial spraying of herbicides in Vietnam have developed significant adverse health effects from that exposure. Detailed surveys of the world's literature have been used in designing the questionnaires, physical examination protocol, and laboratory procedure.

This phase of the study involves a follow-up cross-sectional assessment of the subject's health at the time of examination. It is important that examiners remain unaware of the subject's status as a RANCH HAND participant or as a comparison subject. The physician examiner is tasked to examine and objectively record his findings. The examining physician is not, and cannot be expected to arrive at any definitive diagnosis, since the full history and the laboratory results will not be available to him. Medical history, laboratory results and physical examination findings will be evaluated by an independent diagnostician employed by the contractor. This diagnostician will formulate diagnoses and differential diagnoses, if appropriate. Additional procedures to treat or evaluate emergency or urgent medical conditions will be directed only by this physician. In addition, he will present a detailed analysis and debriefing to the study subject and provide a copy of the analysis to the subject's personal physician, if authorized by the participant.

The physicians performing examinations for the study should be aware that the report of examination will become a permanent record. This report will be referred to not only in the near future as the cross-sectional data is analyzed, but also at the time of future follow-up phases of project. These examinations will define the health status of the subjects at a point in time and will establish the presence or absence of abnormal physical findings. After statistical review of the study groups, these findings may permit definition of a chronic effect due to exposure. An inaccurate examination may lead to fallacious study results in two ways: a presumed syndrome may be defined which does not in fact exist, or a syndrome which in fact exists may not be defined with enough validity to warrant further actions.

The examining physician is responsible for recording a complete and detailed report of the physical examination. In this role, the examining physician is tasked with collecting evidence of the presence or absence of physical signs of abnormality only. All items on the physical examination report form must be completed. It is imperative that the physician make such additional remarks as may be required to adequately describe existing physical and mental impairments. Since clinical endpoints have not been well defined following chronic exposure to Herbicide Orange, the examining physician and the diagnostician must not definitively ascribe

abnormalities to herbicide exposure during the course of the examination or during the patient's debriefing. If, during the examination, the physician discovers evidence of acute serious illness requiring immediate treatment, the normal emergency or urgent care procedure of the medical facility would apply.

The Air Force is not responsible for the cost of such care. If, during the examination, there is evidence of illness requiring nonemergency medical attention, the diagnostician should inform the subject and offer to forward, or have forwarded, pertinent information to the subject's physician. A clear record of any such advice and treatment should be recorded. The ultimate value of the study will lie in the collection of complete, accurate and, whenever possible, quantitative data permitting the most stringent and powerful statistical analysis. For this reason, the physical examination protocol requires exact measurements in many instances and the use of defined meanings of semiquantitative indicators in other places.

B. Conduct of the Examination

1. OVERVIEW:

Upon arrival at the examining facility, the subject should be briefed by the on-site monitor and a representative of the contractor on the appointments which have been arranged, their times, and locations. Consent forms covering all examination procedures shall be provided to each participant. The participant may still decline to participate in any individual portion of the examination, even if he previously signed a consent form.

The examination will be conducted in a manner identical to the process used in prior phases of the study and detailed in the subsequent sections of this handbook and in the Statement of Work.

(a) Hemocult screening of three specimens

(b) Blood pressure determination using automated equipment

(c) Drawing of approximately 350 cc of blood from 500 volunteers to be processed and tested for levels of 2,3,7,8 TCDD. Blood will be drawn and processed in accordance with CDC procedures.

Vietnam Combat questionnaires will only be given to those subjects who did not participate in the 1985 or 1987 examination:

2. PSYCHOLOGICAL BATTERY

a. General

This battery yields objective numerical data. The individual tests were chosen to insure an adequate analysis of one of the major alleged manifestations of herbicide toxicity. Each test either validates one of the other tests, or is considered to be a "definitive" test for analysis of a suspected psycho/neuropathic effect.

b. Specific Tests: Symptom checklist R-90, Millon Multiaxial Clinical Inventory, instruments will be used.

c. Examination Results: Forward all test materials as scored with annotations, interpretations, and impressions to the diagnostician for inclusion in the subject's examination file.

d. The psychologist in charge will conduct a one-to-one test debriefing with each subject to estimate the test-by-test and overall accuracy and validity of the test results and to discuss the results of the tests with the participant. A form for this purpose should be developed and should be filled out completely before forwarding, with the subject's raw data, to the diagnostician. If applicable, input from the testing technician is encouraged.

3. ELECTROCARDIOGRAM

a. A standard 12-lead scalar electrogram is required. If an arrhythmia is observed, a 1-minute rhythm strip is requested, in addition. This electrocardiogram will be accomplished after a minimum of 4-hour abstinence for smoking, food, and liquid intake.

b. Mounting: Mount the tracing in the usual manner of the laboratory for the recorder used.

c. Disposition: Forward the mounted tracing and rhythm strip, if obtained, to the diagnostician.

d. Interpretation: The electrocardiograms will be interpreted by cardiologists at the examination center. Contractor proposals to use automated ECG interpretation will be reviewed by the AF.

4. VISUAL ACUITY SCREENING AND INTRAOCULAR PRESSURE

Screening for near and distant visual acuity will be conducted using equipment and procedures selected by the contractor and approved by the Air Force. Intraocular pressure to screen for the presence of glaucoma will be conducted using tonometry

equipment, which does not come in contact with the cornea, selected by the contractor and approved by the Air Force.

5. PULMONARY FUNCTION TESTING

Standard evaluation of pulmonary function will be conducted on each participant following at least 4 hours abstinence from the use of tobacco products and will include as a minimum forced expiratory volume at 1 second, total vital capacity and the ratio of the two measurements.

6. SCREENING AUDIOMETRY

Screening of hearing will be conducted using equipment and procedures selected by the contractor and approved by the Air Force.

7. AUTOMATED BLOOD PRESSURE DETERMINATION

Pressure, and electronic device will be used to take all blood pressure, measurements. The device to be used will be selected by the contractor and approved by the Air Force.

8. STOOL EXAMINATION FOR OCCULT BLOOD

Three stool specimens from each participant will be tested for the presence of occult blood. Participants with positive tests will be advised and appropriate follow-up will be arranged.

9. RADIOGRAPHIC EXAMINATION

a. Examination: A standard 14x17 in., standing, roentgenogram in the PA position.

b. Interpretation: A board-certified radiologist at the examination center will interpret the roentgenogram and record the results and forward them to the diagnostician.

10. DOPPLER TESTING OF PERIPHERAL PULSES

A Doppler device shall be used to quantitatively measure the peripheral pulses. This procedure will be conducted after a minimum of 4 hour abstinence from smoking, food, and liquid intake.

11. ASSESSMENT OF TESTICULAR SIZE

Contractor will suggest method to assess testicular size.

12. MEASUREMENT OF HEIGHT AND WEIGHT

Determine height in meters and weight in kilograms on each participant. Determine the circumference of the waist at the navel and the circumference of the neck, all in centimeters.

13. VIBROTACTILE THRESHOLD TESTING

Measurement of the vibrotactile threshold in both great toes will be performed using the method of limits and techniques described in Section 4.2, reference 3.

14. LABORATORY PROCEDURES:

a. General Instructions: First Day: The patient should report in the morning in a fasting state having had water only after midnight.

b. General Instructions: Second Day: Serum hormone levels should be determined from specimens collected on the morning of the second day. Hormonal levels appear to oscillate rapidly in a random fashion. Distributions drift with time suggesting diurnal variations and some are affected by nonfasting state. Therefore, patients should be fasting prior to drawing blood for hormone analysis. Serum for dioxin determination will be drawn on 200 participants who consent to this procedure. Sufficient blood will be drawn to bring the total volume over the 2 days to 450 cc from these volunteers. Participants should also be informed that they should abstain from the use of alcohol for 24 hours prior to the scheduled start of the physical examination.

c. Specific Tests to be Performed

- (1) Hematocrit
- (2) Hemoglobin
- (3) Erythrocyte sedimentation rate
- (4) RBC indices
- (5) White blood cell count with differential

- (6) Platelet count
- (7) Urinalysis
- (8) Serum creatinine
- (9) Fasting plasma glucose
- (10) 2-Hour postprandial plasma glucose (accompanied by dipstick test for urine glucose)
- (11) Urobilinogen
- (12) High resolution serum protein electrophoresis to detect adherent B cell clones
- (13) Cholesterol & HDL cholesterol
- (14) Triglycerides
- (15) Bilirubin (total and direct)
- (16) AST
- (17) ALT
- (18) GGT
- (19) Alkaline phosphatase
- (20) LDH
- (21) Hepatitis A antibody
- *(22) Hepatitis B surface antigen
- *(23) Hepatitis B, core antibody
- *(24) Hepatitis B, surface antibody
- *(25) Hepatitis C antibody
- (26) Stool hemocult (3 times)
- (27) Creatine phosphokinase (CPK)

*Testing to be done by USAF on serum drawn and sent by the contractor

- (28) RPR; if positive, send serum to AL/AOELM, Brooks AFB
- (29) Lupus panel (contractor suggested tests)
- (30) Testosterone; total and free
- (31) Thyroid profile (T₄, TSH)
The technique for TSH must be sensitive to hypo- as well as hyperthyroid conditions.
- (32) Prothrombin time
- (33) Serum insulin
- (34) Alpha 1 C hemoglobin
- (35) Rheumatoid Factor
- (36) Serum dioxin determination (to be done by the Centers for Disease Control) on a subset of up to 500 participants selected by the Air Force
- (37) Serum amylase
- (38) Serum ACTH
- (39) Serum LH
- (40) Serum FSH
- (41) Serum glucagon
- (42) Serum estradiol
- (43) Sex hormone binding globulin (SHBG)
- ** (44) Serum proinsulin
- ** (45) Serum C peptide
- ** (46) Islet cell antibodies

**To be done only on participants known to be diabetic (2-hr postprandial glucose > 140 mg/dl.)

d. The following immunological assays will be performed on blood from participants randomly selected using selection procedures outlined in Section 3.1.2.2.2 of the Statement of Work.

- (1) CD3 cells (total T lymphocytes)
- (2) CD4 cells (helper T cells)
- (3) CD5 cells (B cell subset)
- (4) CD8 cells (suppressor T cells)
- (5) CD14 cells (monocytes)
- (6) CD16/56 cells (NK cells)
- (7) CD20 cells (B cells)
- (8) CD25 cells (activated T cells)
- (9) CD45 cells (to be used as a quality control marker)
- (10) Contractor will suggest an approach to detect T cell clones.
- (11) Protein profile
- (12) Delayed hypersensitivity skin tests
- (13) Data from double-labeled cells will be collected for the following combinations:
 - (a) CD3 with CD 25 (refinement of activated T cells)
 - (b) CD5 with CD 20 (B cell subset)
 - (c) CD4/CD8 ratio
 - (d) CD4 with CD8 (abnormal or early T cells)
 - (e) CD3 with CD 16/56 (NK-like T cells)

PARTICIPANT LABEL	CASE NUMBER										GROUP NUMBER												
		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7		8	9
		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7		8	9
		0	1	2	3	4	5	6	7	8	9	EXAMINER I.D. NO.											
		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7		8	9
		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7		8	9
		0	1	2	3	4	5	6	7	8	9		0	1	2	3	4	5	6	7		8	9

FORM AFHS-1 FAMILY AND PERSONAL HISTORY YEAR 10 FOLLOW UP

FAMILY HISTORY

DARKEN NONE OR EACH KNOWN OCCURRENCE OF:	SEX	RELATIVES										NONE	
		GRANDPARENTS		PARENTS		SIBLINGS		CURRENT FAMILY CHILDREN		WIFE	GIRLS		BOYS
		MATERNAL	PATERNAL	MOTHER	FATHER	SISTERS	BROTHERS						
1. ADOPTED	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
2. DIABETES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
3. EPILEPSY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
4. STROKE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
5. HIGH BLOOD PRESSURE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
6. HARDENING OF ARTERIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
7. HEART TROUBLE/ANGINA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
8. BLOOD DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
9. LEUKEMIA	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
10. LUNG CANCER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
11. OTHER CANCER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
12. SMOKING HISTORY	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
13. STOMACH TROUBLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
14. NERVOUS TROUBLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
15. SLEEPING TROUBLE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
16. ALCOHOLISM	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
17. ALZHEIMER'S DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
18. PARKINSON'S DISEASE	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
19. MENTAL DISTURBANCE(S)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
20. ARTHRITIS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
21. BIRTH DEFECTS	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
22. ALLERGIES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							
23. OTHER MEDICAL TROUBLES	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>							

COMMENTS?

SUMMARY OF GENERAL HEALTH QUALITY THROUGHOUT LIFE

RELATION	LIVE BIRTHS		LIFETIME HEALTH IS/WAS?				<input type="radio"/> <input type="radio"/> COMMENTS?	
	# GIRLS	# BOYS	EXCELLENT	GOOD	FAIR	POOR		
NATURAL MOTHER			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
NATURAL FATHER			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
SELF			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
SPOUSE 1 <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
SPOUSE 2 <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
FAMILY MEMBERS	SEX	AGE IN YEARS		IF DECEASED— CAUSE OF DEATH				<input type="radio"/> <input type="radio"/> COMMENTS?
		AT PRESENT IF ALIVE?	AT TIME OF DEATH?	HEART	STROKE	SUICIDE	?	
MOTHER	<input checked="" type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
FATHER	<input checked="" type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	
<input type="radio"/> <input type="radio"/> <input type="radio"/>	<input type="radio"/> <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	

SUMMARY OF TREATMENTS

MONTH/YEAR OF LAST EXAM

- WERE ANY NEW ABNORMALITIES FOUND AT YOUR LAST PHYSICAL EXAMINATION?
- ARE YOU CURRENTLY RECEIVING ANY MEDICATIONS OR TREATMENTS?
- HAVE YOU EVER TAKEN ANY MEDICATIONS OR TREATMENTS FOR LONGER THAN 1 MONTH?
- HAVE YOU EVER HAD A SERIOUS ILLNESS?
- HAVE YOU EVER HAD A SERIOUS INJURY?
- HAVE YOU EVER HAD A SURGICAL OPERATION?

HOW MANY TIMES HAVE YOU BEEN HOSPITALIZED? 0 1 2 3 4 5 6 7 8 9 or more

YEAR	AGE	DESCRIPTION OF OPERATION/INJURY/ILLNESS	MEDICATION/TREATMENT

PERSONAL HISTORY

DARKEN THE BUBBLE IF YOU HAVE EVER EXPERIENCED ONE OF THE FOLLOWING CONDITIONS, OTHERWISE DARKEN .

- | | | | |
|--|---|--|---|
| YES NO | YES NO | YES NO | ANY REPEATING OCCURRENCES IN THE LAST YEAR? |
| <input type="radio"/> <input type="radio"/> CATARACTS | <input type="radio"/> <input type="radio"/> HEPATITIS | <input type="radio"/> <input type="radio"/> MINOR ARTHRITIS | <input type="radio"/> <input type="radio"/> PNEUMONIA |
| <input type="radio"/> <input type="radio"/> TONSILLITIS | <input type="radio"/> <input type="radio"/> WORMS | <input type="radio"/> <input type="radio"/> RHEUMATOID ARTHRITIS | <input type="radio"/> <input type="radio"/> KIDNEY INFECTIONS |
| <input type="radio"/> <input type="radio"/> SINUSITIS | <input type="radio"/> <input type="radio"/> COLITIS | <input type="radio"/> <input type="radio"/> SEVERE ARTHRITIS | <input type="radio"/> <input type="radio"/> SKIN BOILS |
| <input type="radio"/> <input type="radio"/> GOITER | <input type="radio"/> <input type="radio"/> HEMORRHOIDS | <input type="radio"/> <input type="radio"/> SYSTEMIC LUPUS | <input type="radio"/> <input type="radio"/> OTHER INFECTIONS |
| <input type="radio"/> <input type="radio"/> HAY FEVER | <input type="radio"/> <input type="radio"/> KIDNEY STONES | ERYTHEMATOSUS | |
| <input type="radio"/> <input type="radio"/> ASTHMA | <input type="radio"/> <input type="radio"/> KIDNEY TROUBLE | <input type="radio"/> <input type="radio"/> SCLERODERMA | |
| <input type="radio"/> <input type="radio"/> BRONCHITIS | <input type="radio"/> <input type="radio"/> BLADDER TROUBLE | <input type="radio"/> <input type="radio"/> RHEUMATIC FEVER | |
| <input type="radio"/> <input type="radio"/> PLEURISY | <input type="radio"/> <input type="radio"/> PROSTATE TROUBLE | <input type="radio"/> <input type="radio"/> CANCER OR TUMOR | |
| <input type="radio"/> <input type="radio"/> PNEUMONIA | <input type="radio"/> <input type="radio"/> SYPHILIS | <input type="radio"/> <input type="radio"/> VARICOSE VEINS | |
| <input type="radio"/> <input type="radio"/> TUBERCULOSIS | <input type="radio"/> <input type="radio"/> GONORRHEA | <input type="radio"/> <input type="radio"/> PHLEBITIS | |
| <input type="radio"/> <input type="radio"/> HEART TROUBLE | <input type="radio"/> <input type="radio"/> FAINTING | <input type="radio"/> <input type="radio"/> HERNIA (RUPTURE) | |
| <input type="radio"/> <input type="radio"/> STOMACH TROUBLE | <input type="radio"/> <input type="radio"/> FITS OR CONVULSIONS | <input type="radio"/> <input type="radio"/> ANEMIA | |
| <input type="radio"/> <input type="radio"/> ULCERS | <input type="radio"/> <input type="radio"/> DEPRESSION | <input type="radio"/> <input type="radio"/> POLIO | |
| <input type="radio"/> <input type="radio"/> GALLSTONES | <input type="radio"/> <input type="radio"/> NERVOUS BREAKDOWN | <input type="radio"/> <input type="radio"/> MUMPS | |
| <input type="radio"/> <input type="radio"/> JAUNDICE | <input type="radio"/> <input type="radio"/> PARALYSIS | <input type="radio"/> <input type="radio"/> MALARIA | |
| <input type="radio"/> <input type="radio"/> LIVER TROUBLE | <input type="radio"/> <input type="radio"/> MUSCLE PAIN | <input type="radio"/> <input type="radio"/> GOUT | |
| <input type="radio"/> <input type="radio"/> SKIN TROUBLE | <input type="radio"/> <input type="radio"/> MUSCLE WEAKNESS | <input type="radio"/> <input type="radio"/> DIABETES | |
| <input type="radio"/> <input type="radio"/> ACNE | <input type="radio"/> <input type="radio"/> NUMBNESS | <input type="radio"/> <input type="radio"/> MEASLES | |
| <input type="radio"/> <input type="radio"/> EXCESS HAIR GROWTH | <input type="radio"/> <input type="radio"/> LOSS OF SENSATION | <input type="radio"/> <input type="radio"/> DYSENTERY | |
| <input type="radio"/> <input type="radio"/> OTHER SKIN TROUBLE | <input type="radio"/> <input type="radio"/> LOSS OF SEX DRIVE | | |

DESCRIBE OTHER SKIN TROUBLE OR INFECTIONS

COMMENTS?

FORM QA AUDIT BY: <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	DATE	INITIALS
--	------	----------

SUMMARY OF HABITS

How often do you:

	never	less than 12 times/year	1-4 times/month	2-3 times/week	daily
use non-prescription stimulants to stay alert (no-doze, etc)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
use non-prescription sleep aids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
use alcohol to help me sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
take tryptophan to help me sleep	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
take vitamins	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Please indicate below how much you consume on a weekly basis each of the following :
 (If your intake is less than once a week for an item than put a "0" in the space provided)

_____ to _____ 12 oz. cups caffeinated coffee a week	_____ to _____ cigarettes a week
_____ to _____ 12 oz. cups decaf coffee a week	_____ to _____ cigars a week
_____ to _____ 12 oz. cups caffeinated tea a week	_____ to _____ bowls of pipe tobacco a week
_____ to _____ 12 oz. cups decaf tea a week	_____ to _____ pinches of chew a week
_____ to _____ 12 oz. cans sugar cola a week	_____ to _____ 12 oz. cans of regular beer a week
_____ to _____ 12 oz. cans decaf cola a week	_____ to _____ 12 oz. cans of light beer a week
_____ to _____ 12 oz. cans diet cola a week	_____ to _____ 4 oz. glasses of wine a week
_____ to _____ 12 oz. cans decaf diet cola a week	_____ to _____ mixed drinks a week
_____ to _____ 12 oz. cups bottled water a week	_____ to _____ oz. unmixed liquor a week
_____ to _____ 12 oz. cups tap water a week	

Which of the following do you use most often in your coffee? (Choose one from each column)

- | | |
|---------------------------------|--|
| <input type="radio"/> sugar | <input type="radio"/> cream |
| <input type="radio"/> saccharin | <input type="radio"/> milk |
| <input type="radio"/> equal | <input type="radio"/> powdered creamer |
| <input type="radio"/> n/a | <input type="radio"/> n/a |

Which of the following do you use most often in your tea? (Choose one from each column)

- | | |
|---------------------------------|--|
| <input type="radio"/> sugar | <input type="radio"/> cream |
| <input type="radio"/> saccharin | <input type="radio"/> milk |
| <input type="radio"/> equal | <input type="radio"/> powdered creamer |
| <input type="radio"/> n/a | <input type="radio"/> n/a |

Which one of the three following food types do you prefer most?

- steak, salty foods
- bread, sweets
- dairy products

When does your highest energy period occur? (choose one of the following)

- energetic all day
- following meals (especially breakfast and dinner)
- first thing in the morning

Yes No

- Do you have any physical or nervous complaints or concerns?
- Do you have any allergies or severe reactions to: medicines, foods, plants, chemicals, etc? Please specify below.

Comments :

Form QA audit done by :
 ID# Initials Date
 ① ② ③ ④ ⑤ ⑥

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS 1B FAMILY AND PERSONAL HISTORY CONTINUED YEAR 10 FOLLOW UP

GENERAL HEALTH QUALITY OF FAMILY MEMBERS (CONTINUED)

PLEASE NOTE: Only add those family members who you were unable to record on the orange sheet because of a lack of space - you do not have to repeat any relatives.

Family members B = Brother S = Sister C = Child	Sex F M	Age in years		If deceased - what was the cause of death ?						
		At present if alive	At time of death	heart	cancer	stroke	accident	suicide	other	?
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(B) (S) (C)	(F) (M)			<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Comments :

My natural mother gave birth to ____ boys and ____ girls. I was the ____ th child born.
I have sired ____ boy children and ____ girl children.

SUMMARY OF WORK AND LEISURE HOURS

I ____ will retire/ ____ did retire from military service on : _____ at age ____ years.
I ____ will retire/ ____ did retire from work as a civilian on: _____ at age ____ years.
(month/year)
I sleep ____ hours per night during the workweek and ____ hours on other nights.
I take naps ____ times per week for an average of ____ hours per week.

If currently employed, please complete the following:

- I work ____ hours per day ____ days per week.
- I average ____ hours paid overtime per week ____ hours unpaid overtime per week.
- I receive ____ vacation days per year plus ____ paid holidays per year.

SUMMARY OF BODY WEIGHT CHANGES

My current weight range is between ____ lbs and ____ lbs.
My preferred weight range is between ____ lbs and ____ lbs.
The most I ever weighed was ____ lbs and that was between the ages of ____ and ____ years.
The most fit I have ever been was between ages ____ and ____ years, when I weighed ____ lbs and was ____ ft ____ inches tall at the time.
The most weight I ever lost during one period was ____ lbs due to :
 Illness/Injury Stress Dieting Exercise Depression Other

Comments :

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	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	DIAGNOSTICIAN ID NO.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS-2A **REVIEW OF SYSTEMS** YEAR 10 FOLLOW UP

Please ANSWER ALL QUESTIONS. If in doubt, GUESS Yes or No.

If you are bothered by or concerned about the following conditions, darken the **Y** (YES) Bubble. Otherwise mark **N** for NO.

The Doctor or Nurse will ask about the details later.

QUESTIONNAIRE

	HAVE YOU COMMENTED BELOW? Y N
Y N ANY FOODS THAT TEND TO DISAGREE (WHICH ONES?)	
Y N FREQUENT ITCH OR RASH? (WHERE /WHEN?)	
Y N SWELLING, LUMP OR SORENESS ANYWHERE ON BODY? (WHERE?)	
Y N NUMBNESS OR TINGLING? (WHERE?)	
Y N TWITCHING MUSCLES? (WHERE?)	

HOW MANY TIMES DO YOU WAKE FROM SLEEP TO URINATE? 0 1 2 3 4 5 6 7 8 9 OR MORE

YES NO	Q1 - 60 COMMENTS? → Y N	YES NO
Y N 1. SEVERE HEADACHES OR HEAD PAINS		Y N 31. WORRIED ABOUT YOUR HEART
Y N 2. ANY DISTURBANCE IN VISION		Y N 32. BLOOD PRESSURE TOO HIGH
Y N 3. PAIN OR DISCOMFORT IN EYES		Y N 33. BLOOD PRESSURE TOO LOW
Y N 4. WEAR GLASSES (OR CONTACT LENSES?)		Y N 34. PAINS IN HEART OR CHEST
Y N 5. CONSTANT NOISE IN EARS		Y N 35. POUNDING OR SKIPPING OF HEART
Y N 6. HARD OF HEARING		Y N 36. HEART STARTS RACING SUDDENLY
Y N 7. EAR ACHE WITH COLDS		Y N 37. SHORTNESS OF BREATH OR WHEEZING
Y N 8. EAR ACHE WITH PLANE FLIGHTS		Y N 38. TROUBLE GETTING A DEEP BREATH
Y N 9. CHRONIC RUNNING EARS		Y N 39. SWELLING ANKLES
Y N 10. CHRONIC STUFFY OR RUNNY NOSE		Y N 40. LEG CRAMPS IN BED OR SITTING STILL
Y N 11. NEED TO USE NOSE DROPS FREQUENTLY		Y N 41. LEG CRAMPS WHILE WALKING
Y N 12. BAD NOSE BLEEDS AT TIMES		Y N 42. PAIN OR TROUBLE WITH SWALLOWING
Y N 13. FREQUENT SEVERE COLDS OR SORE THROAT		Y N 43. POOR APPETITE RECENTLY
Y N 14. ANY KNOWN DENTAL PROBLEMS		Y N 44. POOR APPETITE ALWAYS
Y N 15. SORENESS OR BLEEDING OF GUMS		Y N 45. NAUSEA OR VOMITING
Y N 16. MORE THAN A YEAR SINCE TEETH CHECKED		Y N 46. VOMITING OF BLOOD
Y N 17. SORE MOUTH OR TONGUE		Y N 47. BELCHING, BLOATING OR INDIGESTION
Y N 18. GOITER OR THYROID TROUBLE		Y N 48. YELLOW SKIN OR EYES (JAUNDICE)
Y N 19. THYROID TEST TOO HIGH		Y N 49. BURNING OR HUNGER PAINS IN STOMACH
Y N 20. THYROID TEST TOO LOW		Y N 50. USE ANTACIDS FOR STOMACH BURNING
Y N 21. FEELING OF LUMP IN THE THROAT		Y N 51. SORENESS OR PAIN IN STOMACH, ABDOMEN
Y N 22. NEED TO TAKE THYROID MEDICINE		Y N 52. SUSPECT ULCERS OR STOMACH TROUBLE
Y N 23. HOARSENESS AT TIMES		Y N 53. CRAMPS IN STOMACH OR LOW DOWN
Y N 24. RECENT OR CHRONIC COUGH		Y N 54. LOOSE BOWELS OR DIARRHEA
Y N 25. CHRONIC COUGHING UP OF SPUTUM		Y N 55. BLACK OR TARRY STOOLS (BOWEL MOVEMENT)
Y N 26. EVER COUGHING UP OF SPUTUM		Y N 56. FRESH OR BRIGHT BLOOD WITH STOOLS
Y N 27. ACHE ALL OVER		Y N 57. MUCUS (SLIME OR PHLEGM) IN STOOLS
Y N 28. HAVING CHILLS OR FEVER		Y N 58. CONSTIPATION
Y N 29. SEVERE SOAKING NIGHT SWEATS		Y N 59. USE LAXATIVES FREQUENTLY
Y N 30. LIVED WITH ANYONE HAVING T.B.		Y N 60. USE ENEMAS FREQUENTLY

PLEASE DO NOT MARK IN THIS SPACE

QUESTIONNAIRE (CONTINUED)

YES NO	Q61 - 118 COMMENTS? → <input type="radio"/> Y <input type="radio"/> N	YES NO
<input type="radio"/> Y <input type="radio"/> N 61. RECENT CHANGE IN BOWEL HABITS		<input type="radio"/> Y <input type="radio"/> N 91. NAIL BITING
<input type="radio"/> Y <input type="radio"/> N 62. RECTAL TROUBLE OR PAIN		<input type="radio"/> Y <input type="radio"/> N 92. SLEEP WALKING
<input type="radio"/> Y <input type="radio"/> N 63. PAIN IN THE KIDNEY REGION		<input type="radio"/> Y <input type="radio"/> N 93. BED WETTING AFTER AGE 12
<input type="radio"/> Y <input type="radio"/> N 64. BLOOD OR PUS IN URINE		<input type="radio"/> Y <input type="radio"/> N 94. CHRONICALLY TIRED OR OVERWORKED
<input type="radio"/> Y <input type="radio"/> N 65. ALBUMIN IN URINE		<input type="radio"/> Y <input type="radio"/> N 95. IRREGULAR LIVING HABITS
<input type="radio"/> Y <input type="radio"/> N 66. SUGAR IN URINE		<input type="radio"/> Y <input type="radio"/> N 96. CAN'T GO TO SLEEP OR STAY ASLEEP
<input type="radio"/> Y <input type="radio"/> N 67. SPELLS OF FREQUENT URINATION		<input type="radio"/> Y <input type="radio"/> N 97. NEARLY ALWAYS IN POOR HEALTH
<input type="radio"/> Y <input type="radio"/> N 68. SEVERE BURNING OR PAIN ON URINATION		<input type="radio"/> Y <input type="radio"/> N 98. CONSIDERED TO BE A NERVOUS PERSON
<input type="radio"/> Y <input type="radio"/> N 69. PAINS OVER BLADDER OR LOW DOWN		<input type="radio"/> Y <input type="radio"/> N 99. FROM SICKLY OR NERVOUS FAMILY
<input type="radio"/> Y <input type="radio"/> N 70. TROUBLE STARTING URINE		<input type="radio"/> Y <input type="radio"/> N 100. TREMBLE AND SWEAT EASILY
<input type="radio"/> Y <input type="radio"/> N 71. URINARY STREAM HAS BECOME WEAK		<input type="radio"/> Y <input type="radio"/> N 101. HAVE TROUBLE MAKING UP YOUR MIND
<input type="radio"/> Y <input type="radio"/> N 72. HARD TO EMPTY BLADDER COMPLETELY		<input type="radio"/> Y <input type="radio"/> N 102. EASILY MIXED UP OR CONFUSED
<input type="radio"/> Y <input type="radio"/> N 73. LOSE CONTROL OF PASSING URINE		<input type="radio"/> Y <input type="radio"/> N 103. CLUMSY OR HAVE FREQUENT ACCIDENTS
<input type="radio"/> Y <input type="radio"/> N 74. PAINFUL OR SORE GENITALS (PRIVATES)		<input type="radio"/> Y <input type="radio"/> N 104. FEEL SAD, LONELY OR DEPRESSED
<input type="radio"/> Y <input type="radio"/> N 75. SWOLLEN OR PAINFUL JOINTS		<input type="radio"/> Y <input type="radio"/> N 105. CRY OFTEN
<input type="radio"/> Y <input type="radio"/> N 76. STIFFNESS OF MUSCLES OR JOINTS		<input type="radio"/> Y <input type="radio"/> N 106. WISH I WERE DEAD
<input type="radio"/> Y <input type="radio"/> N 77. SEVERE PAINS IN ARMS OR LEGS		<input type="radio"/> Y <input type="radio"/> N 107. WORRY CONTINUALLY
<input type="radio"/> Y <input type="radio"/> N 78. PAINFUL FEET		<input type="radio"/> Y <input type="radio"/> N 108. UPSET BY LITTLE THINGS
<input type="radio"/> Y <input type="radio"/> N 79. BACKACHE		<input type="radio"/> Y <input type="radio"/> N 109. A PERFECTIONIST
<input type="radio"/> Y <input type="radio"/> N 80. PAINS IN NECK		<input type="radio"/> Y <input type="radio"/> N 110. SENSITIVE OR FEELINGS EASILY HURT
<input type="radio"/> Y <input type="radio"/> N 81. EASY TO SUNBURN	<input type="radio"/> Y <input type="radio"/> N 111. OFTEN MISUNDERSTOOD	
<input type="radio"/> Y <input type="radio"/> N 82. SUBJECT TO ACNE	<input type="radio"/> Y <input type="radio"/> N 112. OFTEN ACT ON SUDDEN IMPULSE	
<input type="radio"/> Y <input type="radio"/> N 83. SUBJECT TO BOILS OR INFECTION	<input type="radio"/> Y <input type="radio"/> N 113. EASILY ANGERED OR HAVE VIOLENT RAGES	
<input type="radio"/> Y <input type="radio"/> N 84. SUBJECT TO ATHLETE'S FOOT, SKIN FUNGUS	<input type="radio"/> Y <input type="radio"/> N 114. FREQUENTLY KEYED UP AND JITTERY	
<input type="radio"/> Y <input type="radio"/> N 85. SUBJECT TO HIVES OR SKIN REACTIONS	<input type="radio"/> Y <input type="radio"/> N 115. EASILY SCARED BY SUDDEN NOISE	
<input type="radio"/> Y <input type="radio"/> N 86. EASY BLEEDING OR BRUISING	<input type="radio"/> Y <input type="radio"/> N 116. HAVE BAD DREAMS OR THOUGHTS	
<input type="radio"/> Y <input type="radio"/> N 87. MOLE OR SORE WHICH IS NOT HEALING	<input type="radio"/> Y <input type="radio"/> N 117. SUSPECT A SERIOUS DISEASE OR CANCER	
<input type="radio"/> Y <input type="radio"/> N 88. SEVERE DIZZINESS	<input type="radio"/> Y <input type="radio"/> N 118. HAVING TROUBLE GETTING ALONG WITH SOMEONE AT HOME OR AT WORK	
<input type="radio"/> Y <input type="radio"/> N 89. GENERALIZED WEAKNESS		
<input type="radio"/> Y <input type="radio"/> N 90. MUSCLE WEAKNESS		

REVIEWER'S COMMENTS:

	FORM QA AUDIT BY: ID <input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6	DATE	INITIALS
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PARTICIPANT LABEL	CASE NUMBER										GROUP NUMBER										
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	EXAMINER I.D.										0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	

FORM AFHS-3A PHYSICAL EXAMINATION (PART 1)

YEAR 10 FOLLOW UP

GENERAL PHYSICAL APPEARANCE

APPEARANCE	APPEARANCE VS STATED AGE	APPEARANCE OF ILLNESS OR DISTRESS	HAIR DISTRIBUTION
<input type="radio"/> WELL NOURISHED <input type="radio"/> OBESSE <input type="radio"/> UNDER NOURISHED	<input type="radio"/> SAME AS <input type="radio"/> OLDER THAN <input type="radio"/> YOUNGER THAN	<input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL

COMMENTS?

NOTE: FILL IN VITAL SIGNS WITH MAXIMUM VALUES IF REFUSED.

VITAL SIGNS

HEIGHT CM	WEIGHT (UNDRESSED) KG	TEMPERATURE ORAL °F	SITTING BLOOD PRESSURE NONDOMINANT ARM, HEART LEVEL		PULSE RATE	PBs PER MINUTE	PULSE IS: <input type="radio"/> REGULAR <input type="radio"/> IRREGULAR <input type="radio"/> IRREGULARLY IRREGULAR
			SYSTOLIC	DIASTOLIC			
0 0	0 0 0 0	9 0 0	0 0 0	0 0 0	0 0 0	0 0	<input type="checkbox"/> <input type="checkbox"/> COMMENTS?
1 1 1	1 1 1 1	10 1 1	1 1 1	1 1 1	1 1 1	1 1	
2 2 2	2 2 2 2	2 2	2 2 2	2 2	2 2 2	2	
3 3 3	3 3 3 3	3 3	3 3	3 3	3 3 3	3	
4 4	4 4 4	4 4	4 4	4 4	4 4	4	
5 5	5 5 5	5 5	5 5	5 5	5 5	5	
6 6	6 6 6	6 6	6 6	6 6	6 6	6	
7 7	7 7 7	7 7	7 7	7 7	7 7	7	
8 8	8 8 8	8 8	8 8	8 8	8 8	8	
9 9	9 9 9	9 9	9 9	9 9	9 9	9	

EYES

SUMMARY	FUNDOSCOPIC EXAM				EXTERNAL OBSERVATION		
	YES <input type="checkbox"/>	NO <input type="checkbox"/>	↑	YES <input type="checkbox"/>	NO <input type="checkbox"/>	YES <input type="checkbox"/>	NO <input type="checkbox"/>
<input type="radio"/> NORMAL	<input type="checkbox"/>	<input type="checkbox"/>	LIGHT REFLEX	<input type="checkbox"/>	<input type="checkbox"/>	ARCUS SENILIS PRESENT	
<input type="radio"/> ABNORMAL	<input type="checkbox"/>	<input type="checkbox"/>	A-V NICKING	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL OCULAR PIGMENTATION	
<input type="radio"/> REFUSED	<input type="checkbox"/>	<input type="checkbox"/>	ARTERIOLAR SPASM	<input type="checkbox"/>	<input type="checkbox"/>		
<input type="radio"/> LEFT EYE ABSENT	<input type="checkbox"/>	<input type="checkbox"/>	PAPILLEDEMA	<input type="checkbox"/>	<input type="checkbox"/>	↑	CUPPING
<input type="radio"/> RIGHT EYE ABSENT	<input type="checkbox"/>	<input type="checkbox"/>	FUNDI WERE VISUALIZED (B = BOTH, L = LEFT ONLY, R = RIGHT ONLY)	<input type="checkbox"/>	<input type="checkbox"/>		DIABETIC RETINOPATHY

COMMENTS?

CODES

- N = NO OR NONE X = COULD NOT EXAMINE
- Y = YES L = LEFT
- R = REFUSED R = RIGHT

PHYSICAL EXAMINATION
(FORM 3 PART 1 SIDE 2)

ENT/NECK

ENT ARE		LEFT	RIGHT
<input type="radio"/> NORMAL	TYMPANIC MEMBRANE INTACT?	<input type="radio"/> N <input type="radio"/> Y <input type="radio"/> X	<input type="radio"/> N <input type="radio"/> Y <input type="radio"/> X
<input type="radio"/> ABNORMAL	EAR IRRIGATED TO REMOVE WAX?	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
<input type="radio"/> REFUSED	NASAL MUCOSA ULCERATED?	<input type="radio"/> N <input type="radio"/> Y <input type="radio"/> X	<input type="radio"/> N <input type="radio"/> Y <input type="radio"/> X

Y N COMMENTS?

NECK AREA IS	PAROTID GLAND ENLARGED?	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
<input type="radio"/> NORMAL	CAROTID BRUIT PRESENT?	<input type="radio"/> N <input type="radio"/> Y	<input type="radio"/> N <input type="radio"/> Y
<input type="radio"/> ABNORMAL	CAROTID PULSE IS:	<input type="radio"/> N <input type="radio"/> D <input type="radio"/> A	<input type="radio"/> N <input type="radio"/> D <input type="radio"/> A
<input type="radio"/> REFUSED	(N = NORMAL D = DIMINISHED A = ABSENT)		

THYROID GLAND	PALPABLE	ENLARGED	NODULES	TENDER	OTHER
	<input type="radio"/> N <input type="radio"/> Y				

Y N COMMENTS?

THORAX AND LUNGS

CIRCUMFERENCE (CM)

<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL <input type="radio"/> REFUSED <input type="radio"/> Y <input type="radio"/> N COMMENTS?	<input type="radio"/> Y <input type="radio"/> N ASYMMETRICAL EXPANSION <input type="radio"/> Y <input type="radio"/> N HYPERRESONANCE <input type="radio"/> Y <input type="radio"/> N DULLNESS <input type="radio"/> Y <input type="radio"/> N WHEEZES <input type="radio"/> Y <input type="radio"/> N RALES ← (NOTE LOCATION) <input type="radio"/> Y <input type="radio"/> N SUSPECTED COPD ← (DESCRIBE)	WAIST	CHEST AT NIPPLE LEVEL	NECK																																																																																																																
		<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td> </td><td> </td><td> </td></tr> <tr><td>0</td><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td><td>9</td></tr> </table>				0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="3"> </td></tr> <tr><td colspan="3">EXPIRATION</td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td>0</td><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td><td>9</td></tr> </table>				EXPIRATION						0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td colspan="3"> </td></tr> <tr><td colspan="3">INSPIRATION</td></tr> <tr><td> </td><td> </td><td> </td></tr> <tr><td>0</td><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td><td>9</td></tr> </table>				INSPIRATION						0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	
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3	3	3																																																																																																																		
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6	6	6																																																																																																																		
7	7	7																																																																																																																		
8	8	8																																																																																																																		
9	9	9																																																																																																																		

HEART

HEART EXAM IS: <input type="radio"/> NORMAL <input type="radio"/> ABNORMAL <input type="radio"/> REFUSED	MURMUR? <input type="radio"/> NO <input type="radio"/> YES, PROBABLY FUNCTIONAL <input type="radio"/> YES, SUSPECT ORGANIC <input type="radio"/> YES, ORGANIC	INDICATE CHEST AREA(S) TO WHICH MURMUR WAS PROJECTED MOST INTENSELY. (MARK Ns IF NO MURMUR)
ABNORMAL HEART SOUNDS? <input type="radio"/> N <input type="radio"/> Y	AORTIC <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> Y PULMONIC <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> Y APEX <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> Y LLSB <input type="radio"/> N <input type="radio"/> Y <input type="radio"/> N <input type="radio"/> Y	

Y N HEART COMMENTS?

FORM QA AUDIT DONE BY:

ID NUMBER: INITIALS DATE
 1 2 3 4 5 6

GENITOURINARY EXAM

(PE PART 2 CONTINUED)

GENITOURINARY EXAM

- NORMAL
- ABNORMAL
- REFUSED

TESTES

- | | | | | | | |
|-------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|
| | NORMAL | ENLARGED | NODULE | ATROPHIC | ABSENT | OTHER |
| LEFT | <input type="radio"/> |
| RIGHT | <input type="radio"/> |

- | | | | |
|-------------------------|-------------------------|-------------------------|------------------------|
| YES | NO | REFUSED | |
| <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> R | RIGHT INGUINAL HERNIA? |
| <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> R | LEFT INGUINAL HERNIA? |
| <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> R | SCROTAL MASS PRESENT? |

- | | | | | | | | | | | |
|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|-------------------------|---------------------------------------|
| YES | NO | REFUSED | | | | | | | | |
| <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> R | VARICOCELE | | | | | | | |
| <input type="radio"/> Y | <input type="radio"/> N | <input type="radio"/> R | EPIDIDYMAL ABNORMALITY | | | | | | | |
| <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 | SCROTAL MASS SIZE
(DIAMETER IN CM) |

Y N COMMENTS:

RECTAL EXAM

RECTAL EXAM

- NORMAL
- ABNORMAL
- REFUSED

HEMORRHOIDS

- EXTERNAL
- INTERNAL

NONE APPARENT

REFUSED

BLEEDING

THROMBOSED

OTHER

YES NO REFUSED

- | | | | |
|-----------------------|-----------------------|-----------------------|------------------------|
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | PROSTATIC ENLARGEMENT? |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | RECTAL MASS(ES)? |

Y N COMMENTS?

LYMPH NODES

NORMAL

ABNORMAL

REFUSED

- CERVICAL
- OCCIPITAL
- SUPRACLAVICULAR
- AXILLARY
- EPITROCHLEAR
- INGUINAL
- FEMORAL

NORMAL

ENLARGED

TENDER

HARD

FIXED

CONFLUENT

OTHER

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Y N COMMENTS:

SUMMARY OF FOLLOW-UP INDICATED OR RECOMMENDED

SUMMARY OF FINDINGS ENTIRE EXAM WAS:

- ALL NORMAL
- NORMAL WITH NOTED VARIATIONS
- ABNORMAL AS SUMMARIZED
- REFUSED ENTIRE EXAM

- Y N ANY OTHER TESTS INDICATED?
- Y N ANY OTHER TESTS ORDERED?
- Y N OTHER TESTS DESCRIBED?

Y N COMMENTS:

FORM QA AUDIT BY:

1 2 3 4 5 6

INITIALS:

DATE:

PRINTED NAME OF EXAMINING PHYSICIAN

INITIALS / DATE

PARTICIPANT LABEL	CASE NUMBER										GROUP NUMBER										
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	EXAMINER I.D.										
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	

FORM AFHS-4 DERMATOLOGIC EXAMINATION AND BIOPSY

YEAR 10 FOLLOW UP

FOR POSITIVE FINDINGS NOTE TYPE AND LOCATION ON ANATOMICAL CHART AND DARKEN THE APPROPRIATE CIRCLE BELOW

SKIN
 EXAM WAS: NORMAL ABNORMAL REFUSED ANATOMICAL CHART USED? Y N

YES	NO	TYPE		YES	NO	TYPE	
<input type="radio"/>	<input type="radio"/>	1	COMEDONES	<input type="radio"/>	<input type="radio"/>	13	ACTINIC KERATOSES
<input type="radio"/>	<input type="radio"/>	2	ACNEIFORM LESIONS	<input type="radio"/>	<input type="radio"/>	14	PETECHIAE
<input type="radio"/>	<input type="radio"/>	3	ACNEIFORM SCARS	<input type="radio"/>	<input type="radio"/>	15	ECCHYMOSES
<input type="radio"/>	<input type="radio"/>	4	DEPIGMENTATION	<input type="radio"/>	<input type="radio"/>	16	CONJUNCTIVAL ABNORMALITY
<input type="radio"/>	<input type="radio"/>	5	INCLUSION CYSTS	<input type="radio"/>	<input type="radio"/>	17	ORAL MUCOSAL ABNORMALITY
<input type="radio"/>	<input type="radio"/>	6	CUTIS RHOMBOIDALIS	<input type="radio"/>	<input type="radio"/>	18	FINGER NAIL ABNORMALITY
<input type="radio"/>	<input checked="" type="radio"/>	7	HYPERPIGMENTATION	<input type="radio"/>	<input type="radio"/>	19	TOE NAIL ABNORMALITY
<input type="radio"/>	<input type="radio"/>	8	JAUNDICE	<input type="radio"/>	<input type="radio"/>	20	DERMATOGRAPHIA
<input type="radio"/>	<input type="radio"/>	9	SPIDER ANGIOMATA	<input type="radio"/>	<input type="radio"/>	21	SUSPECTED BASAL CELL CARCINOMA
<input type="radio"/>	<input type="radio"/>	10	PALMAR ERYTHEMA	<input type="radio"/>	<input type="radio"/>	22	SUSPECTED SQUAMOUS CELL CARCINOMA
<input type="radio"/>	<input type="radio"/>	11	SUSPECTED MELANOMA	<input type="radio"/>	<input type="radio"/>	23	NEVUS
<input type="radio"/>	<input type="radio"/>	12	PALMAR KERATOSES	<input type="radio"/>	<input type="radio"/>	24	VITILIGO
				<input type="radio"/>	<input type="radio"/>	25	OTHER ABNORMALITY(IES)

SKIN BIOPSY
 BIOPSY NOT INDICATED BIOPSY REFUSED
 BIOPSY INDICATED, IF SO BIOPSY PERFORMED, IF SO REFERRED
 * SAMPLES 0 1 2 3 4 5 6 7 8 9
 YES CONSENT FORM OBTAINED

SAMPLE # TYPE AND LOCATION CODE(S)	(Y) (N) COMMENT(S)/SUSPECTED DIAGNOSIS
------------------------------------	--

PHYSICAL FEATURES

(Y) (N) (X) WEARING COLORED OR TINTED CONTACTS?

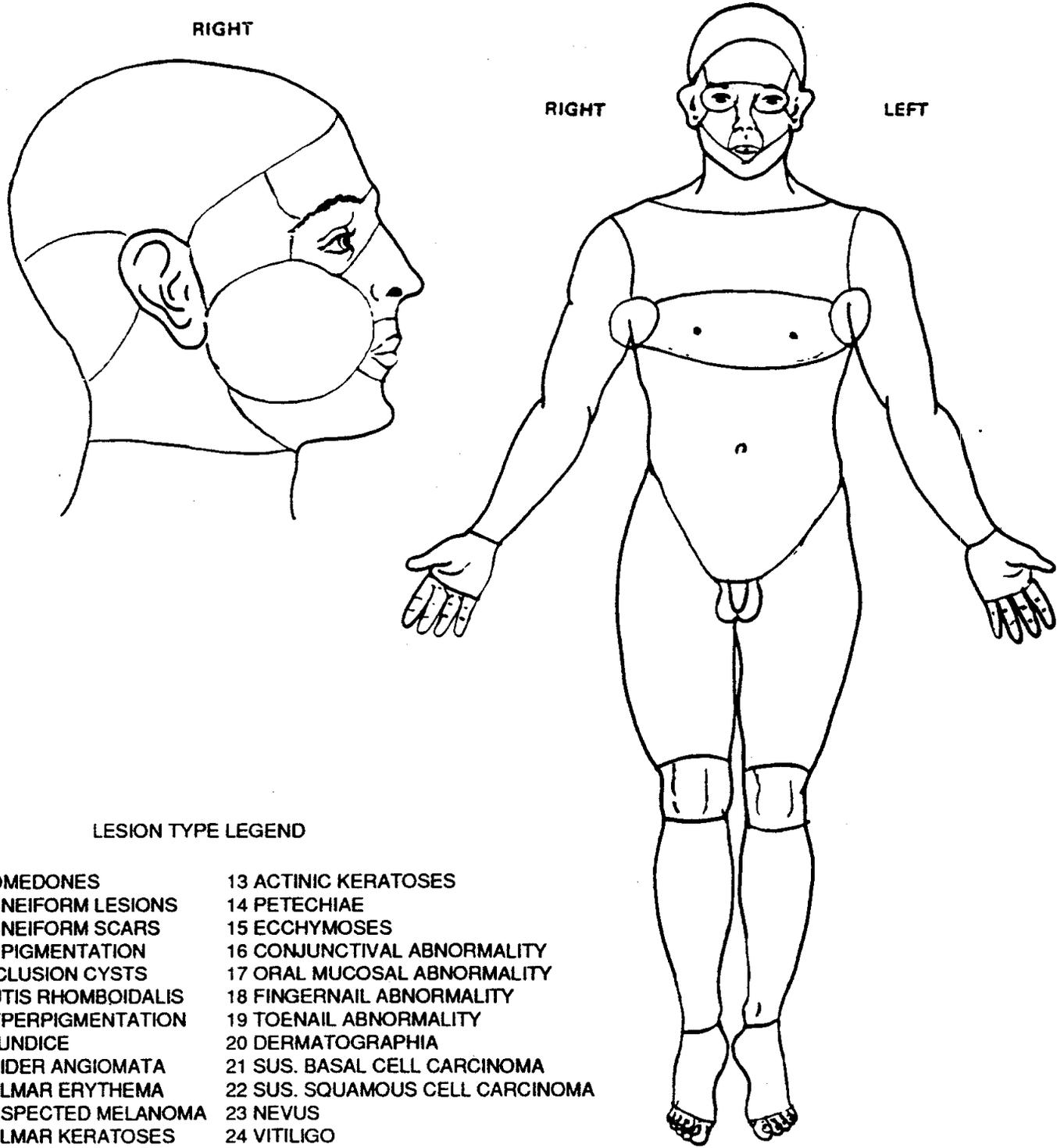
EYE COLOR		HAIR COLOR		SKIN COLOR												
LEFT	RIGHT	SOLID COLOR	GREYS	NN												
BROWN <input type="radio"/>	<input type="radio"/>	BLACKS <input type="radio"/> 1 <input type="radio"/> 34 <input type="radio"/> 44 <input type="radio"/> 51		<input checked="" type="radio"/> 1 <input type="radio"/> 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 <input type="radio"/> 10 <input type="radio"/> 11 <input type="radio"/> 12												
HAZEL <input type="radio"/>	<input type="radio"/>	BROWNS <input type="radio"/> 5 <input type="radio"/> 11 <input type="radio"/> 36 <input type="radio"/> 38 <input type="radio"/> 39 <input type="radio"/> 48 <input type="radio"/> 54														
GREEN <input type="radio"/>	<input type="radio"/>	BLONDS <input type="radio"/> 14 <input type="radio"/> 103 <input type="radio"/> 107														
GREY <input type="radio"/>	<input type="radio"/>	REDS <input type="radio"/> 33 <input type="radio"/> 29														
BLUE <input type="radio"/>	<input type="radio"/>	BALD <input type="radio"/> 0 <input checked="" type="radio"/> NOT NEEDED														
ABSENT <input type="radio"/>	<input type="radio"/>															

(Y) (N) IS HAIR DYED OR ALTERED?

PRINTED NAME OF EXAMINING PHYSICIAN	INITIALS / DATE	FORM QA AUDIT DONE BY:
		ID. NUMBER <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
		INITIALS DATE

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

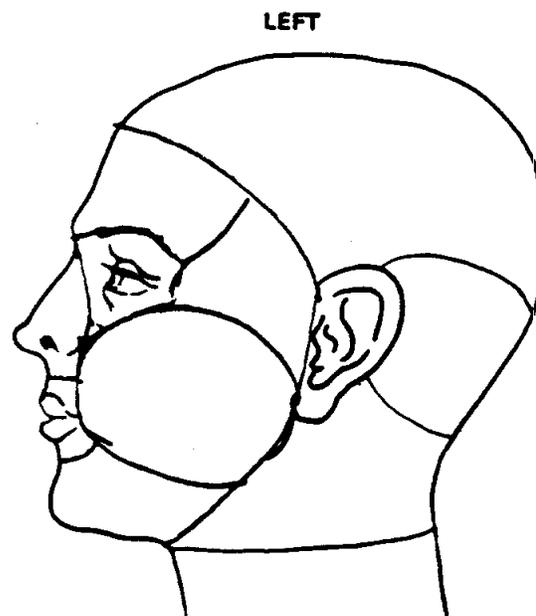
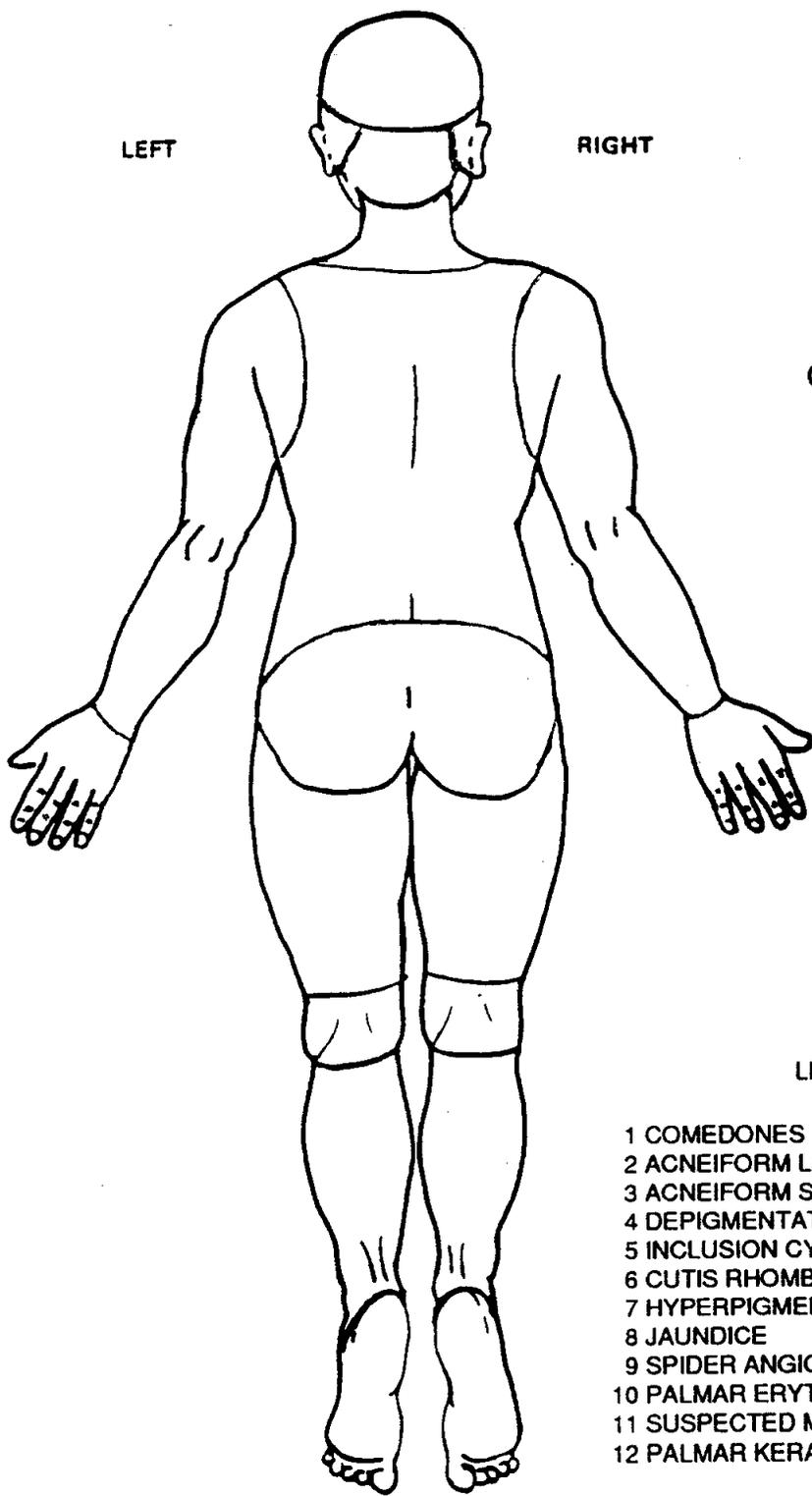
FORM AFHS-9 **ANATOMICAL CHART** YEAR 10 FOLLOW UP



LESION TYPE LEGEND

- | | |
|-----------------------|---------------------------------|
| 1 COMEDONES | 13 ACTINIC KERATOSES |
| 2 ACNEIFORM LESIONS | 14 PETECHIAE |
| 3 ACNEIFORM SCARS | 15 ECCHYMOSES |
| 4 DEPIGMENTATION | 16 CONJUNCTIVAL ABNORMALITY |
| 5 INCLUSION CYSTS | 17 ORAL MUCOSAL ABNORMALITY |
| 6 CUTIS RHOMBOIDALIS | 18 FINGERNAIL ABNORMALITY |
| 7 HYPERPIGMENTATION | 19 TOENAIL ABNORMALITY |
| 8 JAUNDICE | 20 DERMATOGRAPHIA |
| 9 SPIDER ANGIOMATA | 21 SUS. BASAL CELL CARCINOMA |
| 10 PALMAR ERYTHEMA | 22 SUS. SQUAMOUS CELL CARCINOMA |
| 11 SUSPECTED MELANOMA | 23 NEVUS |
| 12 PALMAR KERATOSES | 24 VITILIGO |
| | 25 OTHER ABNORMALITY |

(OVER)



LESION TYPE LEGEND

- | | |
|-----------------------|---------------------------------|
| 1 COMEDONES | 13 ACTINIC KERATOSES |
| 2 ACNEIFORM LESIONS | 14 PETECHIAE |
| 3 ACNEIFORM SCARS | 15 ECCHYMOSES |
| 4 DEPIGMENTATION | 16 CONJUNCTIVAL ABNORMALITY |
| 5 INCLUSION CYSTS | 17 ORAL MUCOSAL ABNORMALITY |
| 6 CUTIS RHOMBOIDALIS | 18 FINGERNAIL ABNORMALITY |
| 7 HYPERPIGMENTATION | 19 TOENAIL ABNORMALITY |
| 8 JAUNDICE | 20 DERMATOGRAPHIA |
| 9 SPIDER ANGIOMATA | 21 SUS. BASAL CELL CARCINOMA |
| 10 PALMAR ERYTHEMA | 22 SUS. SQUAMOUS CELL CARCINOMA |
| 11 SUSPECTED MELANOMA | 23 NEVUS |
| 12 PALMAR KERATOSES | 24 VITILIGO |
| | 25 OTHER ABNORMALITY |

PRINTED NAME OF EXAMING PHYSICIAN	SIGNATURE	DATE
-----------------------------------	-----------	------

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS-5 NEUROLOGIC EXAMINATION

YEAR 10 FOLLOW UP

HEAD AND NECK

INSPECTION AND PALPATION	NECK RANGE OF MOTION	COMMENTS
<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL	<input type="radio"/> NORMAL <input type="radio"/> DECREASED <input type="radio"/> CNE	<input type="radio"/> YES <input type="radio"/> NO
<input checked="" type="radio"/> ASYMMETRY <input checked="" type="radio"/> DEPRESSION <input checked="" type="radio"/> SCAR <input checked="" type="radio"/> OTHER	LEFT <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/> RIGHT <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/> FORWARD <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/> BACKWARD <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/>	

MOTOR SYSTEMS

GAIT	ARM SWING MOVEMENT	HANDEDNESS
<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL <input type="radio"/> COULD NOT EXAMINE	<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL <input type="radio"/> CNE	<input type="radio"/> LEFT <input type="radio"/> RIGHT <input type="radio"/> BOTH
<input checked="" type="radio"/> BROAD BASED <input checked="" type="radio"/> SMALL STEPPED <input checked="" type="radio"/> ATAXIC <input checked="" type="radio"/> OTHER	LEFT <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/> RIGHT <input type="radio"/> <input type="radio"/> <input checked="" type="radio"/>	

YES NO COMMENTS

MUSCLE STATUS

TONE	BULK	ABNORMAL	DECREASED			INCREASED			COMMENTS
			NORMAL	CNE	LEFT	RIGHT	BOTH	LEFT	
UPPER EXTREMITIES		<input checked="" type="radio"/>	<input type="radio"/>						
LOWER EXTREMITIES		<input checked="" type="radio"/>	<input type="radio"/>						
STRENGTH									
DISTAL WRIST EXTENSORS		<input checked="" type="radio"/>	<input type="radio"/>						
ANKLE/TOE FLEXORS		<input checked="" type="radio"/>	<input type="radio"/>						
PROXIMAL DELTOIDS		<input checked="" type="radio"/>	<input type="radio"/>						
HIP FLEXORS		<input checked="" type="radio"/>	<input type="radio"/>						

ABNORMAL MOVEMENTS

TICS, CHOREAS FASCICULATIONS 1 2 3 4 COMMENTS
 TENDERNESS 1 2 3 4

TREMOR(S)

	EXTREMITY				COMMENT	SPEECH	
	UPPER		LOWER			NORMAL	DYSARTHRIA
	LEFT	RIGHT	LEFT	RIGHT			
NO TREMOR	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
RESTING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
ESSENTIAL	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
INTENTION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>
OTHER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>	<input type="radio"/>

COORDINATION

	NORMAL	ABNORMAL			CNE	COMMENTS
		LEFT	RIGHT	BOTH		
1 EQUILIBRATORY (ROMBERG)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	
2 FINGER-NOSE-FINGER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	
3 HEEL-KNEE-SHIN	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	
4 HAND PRONATION/SUPINATION	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	
5 RAPID PATTING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	

DEEP TENDON REFLEXES

(0 = ABSENT, 1 = SLUGGISH, 2 = ACTIVE, 3 = VERY ACTIVE, 4 = TRANSIENT CLONUS, 5 = SUSTAINED CLONUS, X = CNE)

	LEFT						CNE	RIGHT						CNE	COMMENTS
BICEPS	0	1	2	3	4	5	X	0	1	2	3	4	5	X	
TRICEPS	0	1	2	3	4	5	X	0	1	2	3	4	5	X	
PATELLAR	0	1	2	3	4	5	X	0	1	2	3	4	5	X	
ACHILLES	0	1	2	3	4	5	X	0	1	2	3	4	5	X	
BABINSKI	PRESENT						X	ABSENT						X	

CRANIAL NERVES AND MENTAL STATUS

CODES: (X) = COULD NOT EXAMINE, (N) = NO; NOT NORMAL, (Y) = YES, NORMAL
 (R) = DEVIATED TO RIGHT SIDE, (L) = DEVIATED TO LEFT SIDE

MENINGEAL IRRITATION AND SENSORY SYSTEM

	- ABNORMAL -				CNE	Y (N) COMMENTS
	NORMAL	LEFT	RIGHT	BOTH		
STRAIGHT LEG RAISING	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(X)	
LIGHT TOUCH	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(X)	
PIN PRICK	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(X)	
VIBRATION AT ANKLE (128 HZ)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(X)	
POSITION (GREAT TOE)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	(X)	

CRANIAL NERVES (I, VII)

LEFT	RIGHT	Y (N) COMMENTS (I, VII)
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
		SENSE OF SMELL PRESENT?
		SMILE NORMAL?
		PALPEBRAL FISSURE NORMAL?

CRANIAL NERVES (II)

LEFT	RIGHT	Y (N) COMMENTS (II)
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
		FUNDOSCOPIC EXAM NORMAL?
		ABSENCE OF DISK PALLOR/ATROPHY?
		ABSENCE OF EXUDATE?
		ABSENCE OF PAPPILLEDEMA?
		ABSENCE OF HEMORRHAGE?

CRANIAL NERVES (III, IV, VI)

LEFT	RIGHT	Y (N) COMMENTS (III, IV, VI)
(X) (N) (Y)	(X) (N) (Y)	
→	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
		VISUAL FIELDS NORMAL TO CONFRONTATION?
		PUPILS EQUAL SIZE? DIFFERENCE → (0) (1) (2) (3) (4)mm
		PUPIL SHAPE/POSITION ROUND & NORMAL? →
		LIGHT REACTION NORMAL?
		EYE MOVEMENT NORMAL?
		HORIZONTAL NYSTAGMUS
		VERTICAL NYSTAGMUS
		ROTARY NYSTAGMUS
		EYEBALL POSITION NORMAL? →
		PTOSIS ABSENT?
		CORNEAL REFLEX NORMAL?

DRAW ABNORMAL POSITIONS

(O) = CONTACT LENSES NOT REMOVED

CRANIAL NERVES (V, IX, XI, XII)

LEFT	RIGHT	Y (N) COMMENTS (V, IX, XI, XII)
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
(X) (N) (Y)	(X) (N) (Y)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	
	(Y) (N)	
	(R) (L)	

(Y) (N) MENTAL STATUS GROSSLY ORIENTED & NORMAL?

(Y) (N) COMMENTS

IMPRESSION OF ENTIRE NEUROLOGIC EXAM

- COMPLETELY NORMAL EXAM
- NORMAL WITH MINOR VARIATIONS NOTED
- ABNORMAL WITH NO FOLLOW-UP NEEDED
- ABNORMAL WITH FOLLOW-UP RECOMMENDED

(Y) (N) COMMENTS

FORM QA AUDIT DONE BY:

① ② ③ ④ ⑤ ⑥ INITIALS

DATE: **INITIALS:**

PRINTED NAME OF EXAMINING PHYSICIAN

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	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 YEAR 10 FOLLOW-UP

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

- VISIT A RELATIVE
- GO TO A MUSEUM
- 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)

	YES	NO	YES	NO	YES NO
WERE YOU EVER A CREW MEMBER?	<input checked="" type="radio"/>	<input type="radio"/> F-4	<input checked="" type="radio"/>	<input type="radio"/> C-7	<input checked="" type="radio"/> <input type="radio"/> C-130 (GUNSHIP)
	<input checked="" type="radio"/>	<input type="radio"/> F-5	<input checked="" type="radio"/>	<input type="radio"/> C-54	<input checked="" type="radio"/> <input type="radio"/> HELICOPTER GUNSHIP
	<input checked="" type="radio"/>	<input type="radio"/> F-105	<input checked="" type="radio"/>	<input type="radio"/> C-118	<input checked="" type="radio"/> <input type="radio"/> OTHER AIRCRAFT
<input checked="" type="radio"/> YES <input type="radio"/> NO	<input checked="" type="radio"/>	<input type="radio"/> B-52	<input checked="" type="radio"/>	<input type="radio"/> C-123	<div style="border: 1px solid black; padding: 5px; display: inline-block;"> SPECIFY ← </div>
	<input checked="" type="radio"/>	<input type="radio"/> B-66	<input checked="" type="radio"/>	<input type="radio"/> 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

- RECEIVED COMBAT PAY
- CRASH LANDED, BAILED OUT, OR SHOT DOWN
- RECEIVED SNIPER OR SAPPER FIRE IN OR AROUND BASE
- MOVED KILLED OR WOUNDED PERSONNEL
- SERVED AS A FORWARD AIR CONTROLLER (FAC)
- FLEW IN THE SAME AIRCRAFT WHEN FELLOW CREWMEMBER WAS WOUNDED OR KILLED
- FLEW IN THE SAME FORMATION OR ON THE SAME SORTIE WHEN A FELLOW CREWMEMBER WAS WOUNDED OR KILLED

YES NO

- FLEW IN AN AIRCRAFT THAT RECEIVED BATTLE DAMAGE
- RECEIVED INCOMING ARTILLERY OR ROCKET FIRE AT HOME BASE OR CAMP
- ENCOUNTERED MINES OR BOOBY TRAPS
- KILLED VC OR NVA IN STRAFING OR BOMBING RUNS
- WOUNDED
- HAD A CLOSE FRIEND KILLED IN ACTION
- ENGAGED VC OR NVA IN A FIREFIGHT
- CAPTURED BY THE ENEMY

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS-10
ELECTROCARDIOGRAM REPORT
YEAR 10 FOLLOW-UP

ECG EXAM WAS/IS: FOLLOW-UP RECOMMENDED? PARTICIPANT COMPLY WITH 4 HOUR ABSTINENCE TECHNICALLY RHYTHM: NORMAL SINUS	<input type="radio"/> NORMAL <input type="radio"/> NO <input type="radio"/> YES	<input type="radio"/> ABNORMAL <input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> REFUSED <input type="radio"/> YES <input type="radio"/> NO
	<input type="radio"/> SATISFACTORY <input type="radio"/> YES	<input type="radio"/> UNSATISFACTORY <input type="radio"/> NO	

RATE																																																																																		
TACHYCARDIA >100 <table border="1" style="width:100%; text-align:center;"> <tr><td>0</td><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td><td>9</td></tr> </table>	0	0	0	1	1	1	2	2	2	3	3	3	4	4	4	5	5	5	6	6	6	7	7	7	8	8	8	9	9	9	BRADYCARDIA <50 <table border="1" style="width:100%; text-align:center;"> <tr><td>0</td><td>0</td></tr> <tr><td>1</td><td>1</td></tr> <tr><td>2</td><td>2</td></tr> <tr><td>3</td><td>3</td></tr> <tr><td>4</td><td>4</td></tr> <tr><td>5</td><td>5</td></tr> <tr><td>6</td><td>6</td></tr> <tr><td>7</td><td>7</td></tr> <tr><td>8</td><td>8</td></tr> <tr><td>9</td><td>9</td></tr> </table>	0	0	1	1	2	2	3	3	4	4	5	5	6	6	7	7	8	8	9	9	INTERVALS <table style="width:100%;"> <tr> <td style="width:30%;">PR</td> <td style="width:30%;"><input type="radio"/> NORMAL</td> <td style="width:30%;"><input type="radio"/> PROLONGED</td> </tr> <tr> <td>QRS</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> PROLONGED</td> </tr> <tr> <td>QT</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> PROLONGED</td> </tr> <tr> <td>AXIS:</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> RIGHT <input type="radio"/> LEFT</td> </tr> </table> MORPHOLOGY <table style="width:100%;"> <tr> <td style="width:30%;">P-WAVE:</td> <td style="width:30%;"><input type="radio"/> NORMAL</td> <td style="width:30%;"><input type="radio"/> ABNORMAL</td> </tr> <tr> <td>QRS</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> ABNORMAL</td> </tr> <tr> <td></td> <td><input type="radio"/> RBBB</td> <td><input type="radio"/> LBBB</td> </tr> <tr> <td>ST-T</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> ABNORMAL</td> </tr> <tr> <td>Q-WAVE</td> <td><input type="radio"/> NORMAL</td> <td><input type="radio"/> ABNORMAL</td> </tr> <tr> <td>U-WAVE</td> <td><input type="radio"/> PRESENT</td> <td><input type="radio"/> ABSENT</td> </tr> </table>	PR	<input type="radio"/> NORMAL	<input type="radio"/> PROLONGED	QRS	<input type="radio"/> NORMAL	<input type="radio"/> PROLONGED	QT	<input type="radio"/> NORMAL	<input type="radio"/> PROLONGED	AXIS:	<input type="radio"/> NORMAL	<input type="radio"/> RIGHT <input type="radio"/> LEFT	P-WAVE:	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	QRS	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL		<input type="radio"/> RBBB	<input type="radio"/> LBBB	ST-T	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	Q-WAVE	<input type="radio"/> NORMAL	<input type="radio"/> ABNORMAL	U-WAVE	<input type="radio"/> PRESENT	<input type="radio"/> ABSENT
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U-WAVE	<input type="radio"/> PRESENT	<input type="radio"/> ABSENT																																																																																

CHAMBER ENLARGEMENT <table style="width:100%;"> <tr> <td style="width:60%;">RIGHT ATRIAL</td> <td style="width:10%;"><input type="radio"/> Y</td> <td style="width:10%;"><input type="radio"/> N</td> </tr> <tr> <td>LEFT ATRIAL</td> <td><input type="radio"/> Y</td> <td><input type="radio"/> N</td> </tr> <tr> <td>RIGHT VENTRIC</td> <td><input type="radio"/> Y</td> <td><input type="radio"/> N</td> </tr> <tr> <td>LEFT VENTRIC</td> <td><input type="radio"/> Y</td> <td><input type="radio"/> N</td> </tr> </table> <hr/> PRIOR INFARCTION <input type="radio"/> Y <input type="radio"/> N - INFERIOR <input type="radio"/> - ANTEROSEPTAL <input type="radio"/> - ANTERIOR <input type="radio"/> - LATERAL <input type="radio"/>	RIGHT ATRIAL	<input type="radio"/> Y	<input type="radio"/> N	LEFT ATRIAL	<input type="radio"/> Y	<input type="radio"/> N	RIGHT VENTRIC	<input type="radio"/> Y	<input type="radio"/> N	LEFT VENTRIC	<input type="radio"/> Y	<input type="radio"/> N	ARRHYTHMIA? <input type="radio"/> Yes IF YES → RHYTHM STRIP ATTACHED <input type="radio"/> Y <input type="radio"/> N → NOTE TYPE <input type="radio"/> ATRIAL FLUTTER <input type="radio"/> ATRIAL FIBRILLATION <input type="radio"/> JUNCTIONAL RHYTHM <input type="radio"/> MULTIFOCAL ATRIAL RHYTHM <input type="radio"/> MULTIFOCAL <input type="radio"/> PVCs <input type="radio"/> PACS <input type="radio"/> UNIFOCAL <input type="radio"/> PVCs <input type="radio"/> PACS <input type="radio"/> OTHER - A-V NODAL <input type="radio"/> Y <input type="radio"/> N 1st° A-V BLOCK <input type="radio"/> 2nd° A-V BLOCK <input type="radio"/> 3rd° A-V BLOCK <input type="radio"/>
RIGHT ATRIAL	<input type="radio"/> Y	<input type="radio"/> N											
LEFT ATRIAL	<input type="radio"/> Y	<input type="radio"/> N											
RIGHT VENTRIC	<input type="radio"/> Y	<input type="radio"/> N											
LEFT VENTRIC	<input type="radio"/> Y	<input type="radio"/> N											

OTHER LOW QRS VOLTAGE ANEURYSM INFERIOR ANTERIOR ANTEROSEPTAL LATERAL

EARLY REPOLARIZATION WPW LGL OTHER

COMMENTS <input type="radio"/> Y <input type="radio"/> N	<table style="width:100%;"> <tr> <th style="width:15%;">TECHNICIANS</th> <th style="width:15%;">ID#</th> <th style="width:70%;">INITIALS</th> </tr> <tr> <td style="text-align:center;">1 2 3 4 5 6</td> <td></td> <td></td> </tr> </table>	TECHNICIANS	ID#	INITIALS	1 2 3 4 5 6		
TECHNICIANS	ID#	INITIALS					
1 2 3 4 5 6							

PRINTED NAME OF CARDIOLOGIST	ID #	INITIALS	FORM QA AUDIT DONE BY: ID# INITIALS 1 2 3 4 5 6
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ABDOMINAL EVALUATION

TECHNICALLY SATISFACTORY? Y N R

ABNORMALITIES: Y N

MASSES
 ABNORMAL CALCIFICATIONS
 ABNORMAL BOWEL GAS PATTERN
 ABNORMAL BONEY STRUCTURES
 OTHER (USE COMMENT AREA AT RIGHT)
 FOLLOW-UP NEEDED?

COMMENTS/RECOMMENDATIONS:

TECHNICIAN	ID #	INITIALS
1 2 3 4 5 6		
1 2 3 4 5 6		

TESTICULAR ULTRASOUND STUDY

RIGHT TESTICLE

PRESENT ABSENT REFUSED

LENGTH	WIDTH	AP DIAMETER
cm	cm	cm
0 0	0 0	0 0
1 1	1 1	1 1
2 2	2 2	2 2
3 3	3 3	3 3
4 4	4 4	4 4
5 5	5 5	5 5
6 6	6 6	6 6
7 7	7 7	7 7
8 8	8 8	8 8
9 9	9 9	9 9

VOLUME	VOLUME:	
cm	NORMAL	<input type="radio"/>
0 0 0	ABNORMAL	<input type="radio"/>
1 1 1	(IF VOLUME ABNORMAL:)	
2 2 2	VOLUME ENLARGED	<input type="radio"/> Y <input type="radio"/> N
3 3 3	VOLUME DECREASED	<input type="radio"/> Y <input type="radio"/> N
4 4 4		
5 5 5		
6 6 6		
7 7 7		
8 8 8		
9 9 9		

OTHER FINDINGS	SIGNIFICANT:	
MASS	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
CYST	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
OTHER	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
NEEDS FURTHER WORK-UP	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

LEFT TESTICLE

PRESENT ABSENT REFUSED

LENGTH	WIDTH	AP DIAMETER
cm	cm	cm
0 0	0 0	0 0
1 1	1 1	1 1
2 2	2 2	2 2
3 3	3 3	3 3
4 4	4 4	4 4
5 5	5 5	5 5
6 6	6 6	6 6
7 7	7 7	7 7
8 8	8 8	8 8
9 9	9 9	9 9

VOLUME	VOLUME:	
cm	NORMAL	<input type="radio"/>
0 0 0	ABNORMAL	<input type="radio"/>
1 1 1	(IF VOLUME ABNORMAL:)	
2 2 2	VOLUME ENLARGED	<input type="radio"/> Y <input type="radio"/> N
3 3 3	VOLUME DECREASED	<input type="radio"/> Y <input type="radio"/> N
4 4 4		
5 5 5		
6 6 6		
7 7 7		
8 8 8		
9 9 9		

OTHER FINDINGS	SIGNIFICANT:	
MASS	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
CYST	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
OTHER	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
NEEDS FURTHER WORK-UP	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N

TECHNICIAN	ID#	INITIALS
1 2 3 4 5 6		

Y N COMMENTS:

PRINTED NAME OF RADIOLOGIST

ID #

INITIALS

FORM QA AUDIT

DONE BY:

1 2 3 4 5 6

INITIALS

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	DIAGNOSTICIAN ID NO.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS - 14 VASCULAR LABORATORY - DOPPLER YEAR 10 FOLLOW UP

yes no

Are films attached? How Many? _____

Did participant comply with 4 hour abstinence requirement?

		<u>Right</u>		<u>Left</u>
Radial	cne <input checked="" type="radio"/>	0 1 2 3		cne <input checked="" type="radio"/> 0 1 2 3
Femoral	cne <input checked="" type="radio"/>	0 1 2 3		cne <input checked="" type="radio"/> 0 1 2 3
Popliteal	cne <input checked="" type="radio"/>	0 1 2 3		cne <input checked="" type="radio"/> 0 1 2 3
Dorsalis Pedis	cne <input checked="" type="radio"/>	0 1 2 3		cne <input checked="" type="radio"/> 0 1 2 3
Posterior Tibial	cne <input checked="" type="radio"/>	0 1 2 3		cne <input checked="" type="radio"/> 0 1 2 3

Follow-up:

Comments/Recommendations:

Participant refused

PRINTED NAME OF R.V.T.	ID#	INITIALS	TECHNICIAN ID#	INITIALS	FORM QA AUDIT DONE BY: ID#	INITIALS
			0 2 3 4 5 6		1 2 3 4 5 6	

PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER I.D.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
FORM AFHS - 15 VIBROTACTILE THRESHOLD MEASUREMENT			YEAR 10 FOLLOW-UP

TRIAL #1

DESCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #2

ASCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #3

DESCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #4

ASCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #5

DESCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #6

ASCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

TRIAL #7

DESCENDING

RIGHT	LEFT
--------------	-------------

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

REFUSED
 COULD NOT EXAMINE
 COMMENT?

EXAMINER NAME	ID#	INITIALS	QA AUDIT BY: INITIALS ① ② ③ ④ ⑤ ⑥
----------------------	------------	-----------------	---

PARTICIPANT LABEL	CASE NUMBER								GROUP NUMBER												
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5		6	7	8	9
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5		6	7	8	9
	EXAMINER ID																				
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5		6	7	8	9
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5		6	7	8	9

FORM AFHS-20 AUDIOLOGY

YEAR 10 FOLLOW UP

AUDIOMETER: MAICO 40 ANSI 1969 888 = NO RESPONSE 999 = NOT TESTED

PURE TONE AUDIOMETRY RESULTS

FREQUENCY IN HERTZ

LEFT EAR								HZ	RIGHT EAR							
250	500	1000	2000	3000	4000	6000	8000		250	500	1000	2000	3000	4000	6000	8000
0	0	0	0	0	0	0	0	DB	0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	
2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	
3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	
4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	4	
5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	5	
6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	6	
7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	7	
8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	8	
9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	9	

RELIABILITY: <input type="radio"/> GOOD <input type="radio"/> FAIR <input type="radio"/> QUESTIONABLE <input type="radio"/> REFUSED TEST	HEARING AID USE: <input type="radio"/> NONE <input type="radio"/> LEFT EAR <input type="radio"/> RIGHT EAR <input type="radio"/> BOTH EARS	TINNITUS: NONE <input type="radio"/> L <input type="radio"/> R <input type="radio"/> B MILD <input type="radio"/> L <input type="radio"/> R <input type="radio"/> B MODERATE <input type="radio"/> L <input type="radio"/> R <input type="radio"/> B SEVERE <input type="radio"/> L <input type="radio"/> R <input type="radio"/> B	<input checked="" type="radio"/> <input type="radio"/> COMMENTS?
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INTERPRETATION

HEARING ABILITY	LOW FREQUENCIES (250 HZ to 500 HZ)		MID FREQUENCIES (1000 HZ to 2000 HZ)		HIGH FREQUENCIES (3000 HZ to 8000 HZ)	
	AS	AD	AS	AD	AS	AD
NORMAL LOSS (0-25 Db)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MILD LOSS (30-40 Db)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MODERATE LOSS (45-60 Db)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
SEVERE LOSS (65-85 Db)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PROFOUND LOSS (90-110+ Db)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
COULD NOT EXAMINE	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>	<input checked="" type="radio"/>
	LEFT	RIGHT	LEFT	RIGHT	LEFT	RIGHT

SUMMARY AND RECOMMENDATIONS

<input type="radio"/> NORMAL HEARING BILATERALLY <input type="radio"/> ABNORMAL FINDINGS <input type="radio"/> REFUSED EXAM	YES <input checked="" type="radio"/> NO <input type="radio"/> <input checked="" type="radio"/> ADDITIONAL TESTS RECOMMENDED? <input checked="" type="radio"/> CONSIDER HEARING AID CONSULTATION AND/OR TRIAL?
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RECOMMENDATIONS OR OTHER COMMENTS?

PRINTED NAME OF AUDIOLOGIST	INITIALS: / DATE:	FORM QA AUDIT DONE BY: ID # ①②③④⑤⑥ INITIALS: DATE:
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PARTICIPANT LABEL	CASE NUMBER	GROUP NUMBER	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	EXAMINER ID.	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	
	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	

FORM AFHS-21 TITMUS VISION SCREEN & TONOMETRY

YEAR 10 FOLLOW UP

FAR VISION TESTS (20 FEET)

<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL	TARGET:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	NOT TESTED
	SNELLEN EQUIVALENTS	$\frac{20}{200}$	$\frac{20}{100}$	$\frac{20}{70}$	$\frac{20}{50}$	$\frac{20}{40}$	$\frac{20}{35}$	$\frac{20}{30}$	$\frac{20}{25}$	$\frac{20}{22}$	$\frac{20}{20}$	$\frac{20}{18}$	$\frac{20}{17}$	$\frac{20}{15}$	$\frac{20}{13}$		
LEFT CORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
RIGHT CORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
LEFT UNCORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
RIGHT UNCORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														

STEREO DEPTH PERCEPTION

<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL	STEREO DEPTH (SHEPARD-FRY %)		1	2	3	4	5	6	7	8	9	NOT TESTED
		15%	30%	50%	60%	70%	80%	85%	90%	95%		<input checked="" type="radio"/>
	_____	<input type="radio"/>	<input checked="" type="radio"/>									

COLOR VISION (STANDARD ISHIHARA PLATES)

<input type="radio"/> NORMAL (4-6 CORRECT) <input type="radio"/> PARTIALLY COLOR BLIND <input type="radio"/> COLOR BLIND (ONLY 1 CORRECT)		A	B	C	D	E	F	NOT TESTED
		12	5	26	6	16	0	<input checked="" type="radio"/>
		<input type="radio"/>	<input checked="" type="radio"/>					

VERTICAL STEREO FOCUS

HYPERPHORIA? NONE LEFT <input type="radio"/> RT <input type="radio"/> BOTH <input type="radio"/> CNE <input checked="" type="radio"/>	PRISM DIOPTERS:		1	2	3	4	5	6	7	NOT TESTED
		$1\frac{1}{2}$	1	$\frac{1}{2}$	*	$\frac{1}{2}$	1	$1\frac{1}{2}$		<input checked="" type="radio"/>
		<input type="radio"/>								

LATERAL STEREO FOCUS

<input type="radio"/> NORMAL <input type="radio"/> ESOPHORIA <input type="radio"/> EXOPHORIA		ESOPHORIA					EXOPHORIA										
	PRISM DIOPTERS:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	NOT TESTED
		7	6	5	4	3	2	1	*	1	2	3	4	5	6	7	<input checked="" type="radio"/>

NEAR VISION TESTS (14 INCHES)

<input type="radio"/> NORMAL <input type="radio"/> ABNORMAL	TARGET:		1	2	3	4	5	6	7	8	9	10	11	12	13	14	NOT TESTED
	SNELLEN EQUIVALENTS	$\frac{20}{200}$	$\frac{20}{100}$	$\frac{20}{70}$	$\frac{20}{50}$	$\frac{20}{40}$	$\frac{20}{35}$	$\frac{20}{30}$	$\frac{20}{25}$	$\frac{20}{22}$	$\frac{20}{20}$	$\frac{20}{18}$	$\frac{20}{17}$	$\frac{20}{15}$	$\frac{20}{13}$		
LEFT CORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
RIGHT CORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
LEFT UNCORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														
RIGHT UNCORRECTED	_____	<input type="radio"/>	<input checked="" type="radio"/>														

TONOMETRY (NON CONTACT TONOMETER)

	NORMAL	ABNORMAL	NOT TESTED	LEFT EYE					RIGHT EYE					
LEFT	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	PRESSURE	0	1	2	3	4	0	1	2	3	4
RIGHT	<input type="radio"/>	<input type="radio"/>	<input checked="" type="radio"/>	MM HG	0	1	2	3	4	5	6	7	8	9

ADDITIONAL TESTS RECOMMENDED?

COMMENTS?

FORM QA AUDIT BY:
① ② ③ ④ ⑤ ⑥ INITIALS:

PARTICIPANT LABEL	CASE NUMBER										GROUP NUMBER									
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
											EXAMINER I.D.									
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
	0	1	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9



FORM AFHS - 22 HEMOCCULT EXAM 10 YEAR FOLLOWUP

PART 1 Please record the date of each stool sampled below and describe any alterations from the hemoccult diet. The clinic will complete part 2.

	PACKET 1	PACKET 2	PACKET 3
Date of smear:	___/___/___	___/___/___	___/___/___
Comply with diet?	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N	<input type="radio"/> Y <input type="radio"/> N
Comments:			

PART 2 SKD HEMOCCULT II SLIDE SAMPLE KIT EXAMINATION RESULTS
(to be completed by the clinic)

	PACKET 1	PACKET 2	PACKET 3
RESULTS :	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

("+" = Positive, "-" = No Reaction or Negative, "x" = No Sample Provided)

SLIDE SAMPLE KIT WAS: <input type="radio"/> Complete (all 3 packets) <input type="radio"/> Incomplete (< 3 packets) <input type="radio"/> Sampled at rectal exam (0 packets)	HEMOCCULT EXAM WAS : <input type="radio"/> All negative <input type="radio"/> At least 1 positive
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Comments/Recommendations:

PRINTED NAME OF GASTROENTEROLOGIST	ID#	INITIALS	DATE	FORM QA AUDIT DONE BY
				ID# INITIALS DATE
				①②③④⑤⑥

0	1	2	3	4	5	6	7	8	9
0	1	2	3	4	5	6	7	8	9



EVALUATION

Dear Health Study Participant:

To serve you and future study participants in the best way possible, please complete this short evaluation form. The form may be completed and delivered to the Health Study Logistic Coordinator following your outbriefing at the Scripps Clinic on the third day of your examination.

	excellent	good	satisfactory	unsatisfactory
Initial phone contact and recruitment	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Travel agent contact and travel arrangements	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Logistics Information Packet (mailed)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Airport/Hotel shuttle service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hotel/Clinic van service	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hotel accommodations	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Evening orientation meeting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Wives orientation meeting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cafeteria meals at the Clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Examination schedule at the Clinic	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Technicians (e.g., blood draw)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Interviews	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nursing Staff	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Psychologists	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Examining physicians	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Clinical outbriefing	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Air Force Health Study Monitor	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Overall clinical experience	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Did any examining physician ask about your specific duties in Southeast Asia? yes no
 (If yes, please see the Air Force On-site Monitor)

Additional comments or acknowledgements: _____

 Name: _____ (not required)

Mailing Address: Air Force Health Study M/S D4
 Science Applications International Corporation
 10260 Campus Point Drive
 San Diego, California 92121