

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	<b>EXAMINER I.D.</b>	
	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 (SHEET 2 OF 2)

YEAR 15 FOLLOW UP

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

CRANIAL NERVES (I, VII)

LEFT	RIGHT		(Y) (N) COMMENTS (I, VII)	
(X) (N) (Y)	(X) (N) (Y)			
(X) (N) (Y)	(X) (N) (Y)	SMILE NORMAL?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	PALPEBRAL FISSURE NORMAL?		<input type="radio"/>

CRANIAL NERVES (II)

LEFT	RIGHT		(Y) (N) COMMENTS (II)	
(X) (N) (Y)	(X) (N) (Y)			
(X) (N) (Y)	(X) (N) (Y)	ABSENCE OF DISK PALLOR/ATROPHY?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	ABSENCE OF EXUDATE?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	ABSENCE OF PAPILLEDEMA?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	ABSENCE OF HEMORRHAGE?		<input type="radio"/>

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)	VISUAL FIELDS NORMAL TO CONFRONTATION?		<input type="radio"/>
→ (X) (N) (Y)	→ (X) (N) (Y)	PUPILS EQUAL SIZE? DIFFERENCE → 0 1 2 3 4 mm		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	PUPIL SHAPE/POSITION ROUND & NORMAL? →	<div style="border: 1px solid black; padding: 5px; width: fit-content; margin: auto;">DRAW ABNORMAL POSITIONS</div>	<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	LIGHT REACTION NORMAL?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	HORIZONTAL NYSTAGMUS		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	VERTICAL NYSTAGMUS		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	ROTARY NYSTAGMUS		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	EYEBALL POSITION NORMAL? →		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	PTOSIS ABSENT?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	CORNEAL REFLEX NORMAL?		<input type="radio"/>

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)	TRIGEMINAL V2 SENSORY NORMAL?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	TRIGEMINAL V3 SENSORY NORMAL?		<input type="radio"/>
(X) (N) (Y)	(X) (N) (Y)	PALATE REFLEX NORMAL?		<input type="radio"/>
	(Y) (N)      (R) (L)	TONGUE PROTRUDES TO MIDDLE, NOT DEVIATED?		<input type="radio"/>
	(Y) (N)      (R) (L)	TONGUE NORMAL, NOT ATROPHIED?		<input type="radio"/>
	(Y) (N)      (R) (L)	CLENCH JAW SYMMETRIC (NOT DEVIATED)?		<input type="radio"/>
	(Y) (N)      (R) (L)	PALATE & UVULA MOVEMENT (NOT DEVIATED)?		<input type="radio"/>

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

(Y) (N) COMMENTS

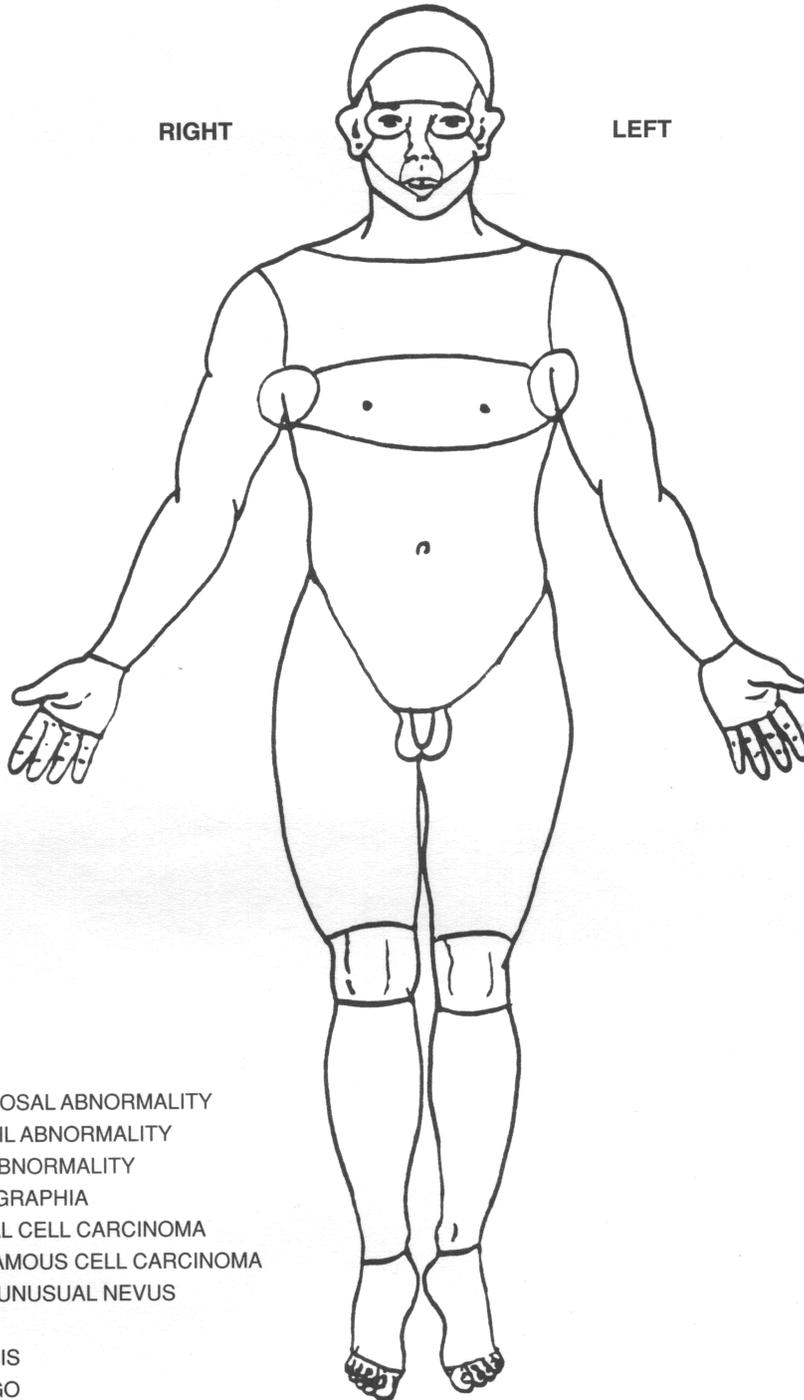
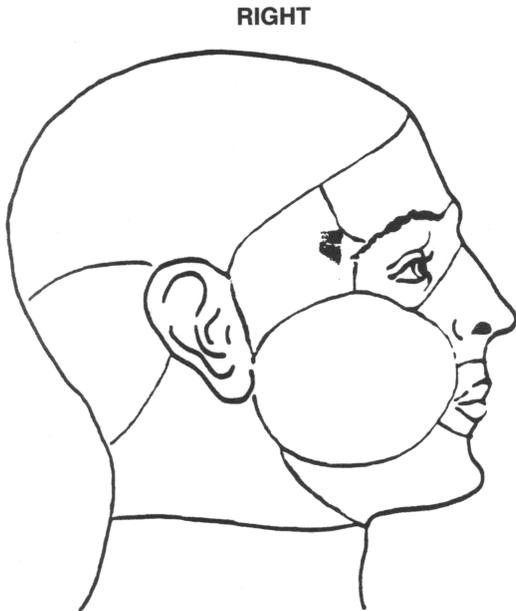
IMPRESSION OF ENTIRE NEUROLOGIC EXAM

<input type="radio"/> COMPLETELY NORMAL EXAM <input type="radio"/> NORMAL WITH MINOR VARIATIONS NOTED <input type="radio"/> ABNORMAL WITH NO FOLLOW-UP NEEDED <input type="radio"/> ABNORMAL WITH FOLLOW-UP RECOMMENDED	(Y) (N) COMMENTS <hr/> PRINTED NAME OF EXAMINING PHYSICIAN/DATE	FORM QA AUDIT BY: 1 2 3 4 5 6 INITIALS: <hr/> DATE:
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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	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 - 9 ANATOMICAL CHART (SHEET 1 OF 2)** **YEAR 15 FOLLOW UP**



(Y)  (N) LESION(S) PRESENT ON FRONT

**LESION TYPE LEGEND**

- |                             |                                 |
|-----------------------------|---------------------------------|
| 1 COMEDONES                 | 17 ORAL MUCOSAL ABNORMALITY     |
| 2 ACNEIFORM LESIONS         | 18 FINGERNAIL ABNORMALITY       |
| 3 ACNEIFORM SCARS           | 19 TOENAIL ABNORMALITY          |
| 4 DEPIGMENTATION            | 20 DERMATOGRAPHIA               |
| 5 INCLUSION CYSTS           | 21 SUS. BASAL CELL CARCINOMA    |
| 6 CUTIS RHOMBOIDALIS        | 22 SUS. SQUAMOUS CELL CARCINOMA |
| 7 HYPERPIGMENTATION         | 23 ATYPICAL/UNUSUAL NEVUS       |
| 8 JAUNDICE                  | 24 VITILIGO                     |
| 9 SPIDER ANGIOMATA          | 25 TINEA PEDIS                  |
| 10 PALMAR ERYTHEMA          | 26 INTERTRIGO                   |
| 11 SUSPECTED MELANOMA       | 27 LIPOMA                       |
| 12 PALMAR KERATOSES         | 28 ECZEMA                       |
| 13 ACTINIC KERATOSES        | 29 PSORIASIS                    |
| 14 PETECHIAE                | 30 SEBORRHEIC DERMATITIS        |
| 15 ECCHYMOSES               | 31 OTHER ABNORMALITY(IES)       |
| 16 CONJUNCTIVAL ABNORMALITY |                                 |

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

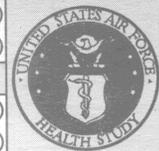
PARTICIPANT LABEL

CASE NUMBER

GROUP NUMBER

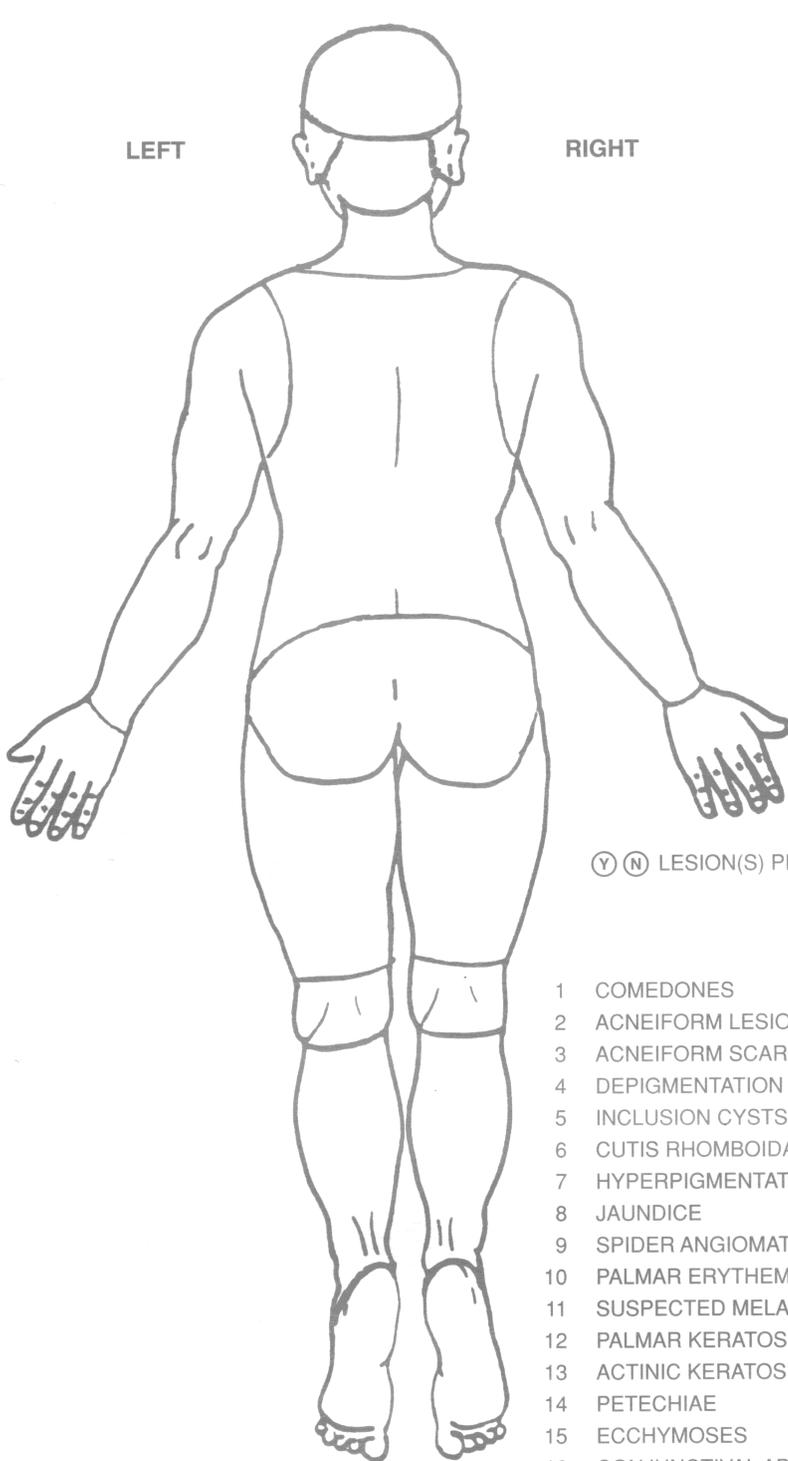
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0	1	2	3	4	5	6	7	8	9

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0	1	2	3	4	5	6	7	8	9
EXAMINER I.D.									
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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 (SHEET 2 OF 2)

YEAR 15 FOLLOW UP



(Y) (N) LESION(S) PRESENT ON BACK

LESION TYPE LEGEND

- |    |                          |    |                              |
|----|--------------------------|----|------------------------------|
| 1  | COMEDONES                | 17 | ORAL MUCOSAL ABNORMALITY     |
| 2  | ACNEIFORM LESIONS        | 18 | FINGERNAIL ABNORMALITY       |
| 3  | ACNEIFORM SCARS          | 19 | TOENAIL ABNORMALITY          |
| 4  | DEPIGMENTATION           | 20 | DERMATOGRAPHIA               |
| 5  | INCLUSION CYSTS          | 21 | SUS. BASAL CELL CARCINOMA    |
| 6  | CUTIS RHOMBOIDALIS       | 22 | SUS. SQUAMOUS CELL CARCINOMA |
| 7  | HYPERPIGMENTATION        | 23 | ATYPICAL/UNUSUAL NEVUS       |
| 8  | JAUNDICE                 | 24 | VITILIGO                     |
| 9  | SPIDER ANGIOMATA         | 25 | TINEA PEDIS                  |
| 10 | PALMAR ERYTHEMA          | 26 | INTERTRIGO                   |
| 11 | SUSPECTED MELANOMA       | 27 | LIPOMA                       |
| 12 | PALMAR KERATOSES         | 28 | ECZEMA                       |
| 13 | ACTINIC KERATOSES        | 29 | PSORIASIS                    |
| 14 | PETECHIAE                | 30 | SEBORRHEIC DERMATITIS        |
| 15 | ECCHYMOSES               | 31 | OTHER ABNORMALITY(IES)       |
| 16 | CONJUNCTIVAL ABNORMALITY |    |                              |

PRINTED NAME OF EXAMINING PHYSICIAN

SIGNATURE/DATE

FORM QA AUDIT BY:

(1) (2) (3) (4) (5) (6) 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
										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 EXAMINATION**

**YEAR 15 FOLLOW UP**

**PART 1**

( TO BE COMPLETED BY PARTICIPANT )

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

Date of smear:	PACKET 1			PACKET 2			PACKET 3		
	MO	DAY	YR	MO	DAY	YR	MO	DAY	YR
	0	0	0	0	0	0	0	0	0
	1	1	1	1	1	1	1	1	1
	2	2	2	2	2	2	2	2	2
	3	3	3	3	3	3	3	3	3
	4	4	4	4	4	4	4	4	4
	5	5	5	5	5	5	5	5	5
	6	6	6	6	6	6	6	6	6
	7	7	7	7	7	7	7	7	7
	8	8	8	8	8	8	8	8	8
	9	9	9	9	9	9	9	9	9

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
-------------------	-------------------------	-------------------------	-------------------------	-------------------------	-------------------------	-------------------------

Y  N COMMENTS:

**PART 2 SKD HEMOCCULT II SLIDE SAMPLE KIT EXAMINATION RESULTS**

( TO BE COMPLETED BY THE CLINIC )

Results:	PACKET 1	PACKET 2	PACKET 3
	<input type="radio"/> Positive	<input type="radio"/> Positive	<input type="radio"/> Positive
	<input type="radio"/> Negative	<input type="radio"/> Negative	<input type="radio"/> Negative
	<input type="radio"/> No sample	<input type="radio"/> No sample	<input type="radio"/> No sample

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

Y  N COMMENTS/RECOMMENDATIONS:

PRINTED NAME OF GASTROENTEROLOGIST	ID #    INITIALS    DATE _____	FORM QA AUDIT BY: ① ② ③ ④ ⑤ ⑥ INITIALS: _____
		DATE:

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



YEAR 15 FOLLOW-UP

**FORM AFHS - 31 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 second day of your examination.

	excellent	good	satisfactory	unsatisfactory	not applicable
Initial phone contact and recruitment	<input type="radio"/>				
Travel agent contact and travel arrangements	<input type="radio"/>				
Logistics Information Packet (mailed)	<input type="radio"/>				
Airport/Hotel shuttle service	<input type="radio"/>				
Hotel/Clinic van service	<input type="radio"/>				
Hotel accommodations	<input type="radio"/>				
Evening orientation meeting	<input type="radio"/>				
Wives orientation meeting	<input type="radio"/>				
Cafeteria meals at the Clinic	<input type="radio"/>				
Examination schedule at the Clinic	<input type="radio"/>				
Technicians (e.g., blood draw)	<input type="radio"/>				
Interviews	<input type="radio"/>				
Nursing Staff	<input type="radio"/>				
Psychological tests	<input type="radio"/>				
Examining physicians	<input type="radio"/>				
Clinical outbriefing	<input type="radio"/>				
Air Force Health Study Monitor	<input type="radio"/>				
Overall clinical experience	<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 immediately)

Additional comments or acknowledgements: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Name: \_\_\_\_\_  
 (not required)

Mailing Address: **Air Force Health Study M/S C5  
 Science Applications International Corporation  
 10260 Campus Point Drive  
 San Diego, California 92121**

PARTICIPANT LABEL	CASE NUMBER										GROUP NUMBER												
	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="text"/>	0	1	2	3	4	5	6	7		8	9
	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="text"/>	0	1	2	3	4	5	6	7		8	9
	<input type="text"/>	EXAMINER I.D.										<input type="text"/>	0	1	2	3	4	5	6	7		8	9
	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="text"/>	0	1	2	3	4	5	6	7		8	9
	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="text"/>	0	1	2	3	4	5	6	7		8	9

**FORM AFHS - 33 CHECKLIST FOR PARTICIPANT FOLDER**

**YEAR 15 FOLLOW UP**

N O R C	P I C	3 3 4 4		16 16	S J P L								
<input type="radio"/>	<input type="radio"/>	A B A B	5	9 10 11 14 A B 22 32	C N U A								
		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	L K L B							
		<input type="radio"/>											
				T C T									<input type="radio"/>

BLOOD DRAW INDICATED?	<input type="radio"/> Y <input type="radio"/> N	DIOX	<input type="radio"/> Y <input type="radio"/> N	IMMUNE	<input type="radio"/> Y <input type="radio"/> N	DX	<input type="radio"/>	IM	<input type="radio"/>	FOLLOW-UP INDICATED?	<input type="radio"/> Y <input type="radio"/> N
DONE?	<input type="radio"/> Y <input type="radio"/> N		<input type="radio"/> Y <input type="radio"/> N	REFUSED			<input type="radio"/>		<input type="radio"/>	AUTHORIZATIONS ENCL.?	<input type="radio"/> Y <input type="radio"/> N
				RECENT OPERATION			<input type="radio"/>		<input type="radio"/>	COPY LETTER ENCLOSED?	<input type="radio"/> Y <input type="radio"/> N
				GAVE BLOOD RECENTLY			<input type="radio"/>		<input type="radio"/>	CONSENT FORMS ENCLOSED?	
				HEMOGLOBIN < 12.5			<input type="radio"/>		<input type="radio"/>	PHYS EX/PSYCH	<input type="radio"/> Y <input type="radio"/> N
				SICK (HAD TEMP. ETC)			<input type="radio"/>		<input type="radio"/>	ADIPOSE TISSUE	<input type="radio"/> Y <input type="radio"/> N
				OTHER:			<input type="radio"/>		<input type="radio"/>	HIV TEST	<input type="radio"/> Y <input type="radio"/> N
							<input type="radio"/>		<input type="radio"/>	SKIN BIOPSY	<input type="radio"/> Y <input type="radio"/> N
							<input type="radio"/>		<input type="radio"/>		<input type="radio"/> Y <input type="radio"/> N
							<input type="radio"/>		<input type="radio"/>	HEMOCCULT SLIDE ENCL?	<input type="radio"/> Y <input type="radio"/> N
							<input type="radio"/>		<input type="radio"/>	MEDICAL RECORDS	<input type="radio"/> P <input type="radio"/> S <input type="radio"/> C

PLEASE SPECIFY OTHER:

DX \_\_\_\_\_

IM \_\_\_\_\_

INCIDENT?  Y  N

MONITOR ID  1  2  3  4  5  6

COMMENTS:  Y  N

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---



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A

B

C

D

E

**LEGEND:** P=INDIVID PHOTO ENCLOSED FORM 10: T=ECG TRACINGS ENCLOSED  
 FORM 11: C=CHEST (X-RAY ENCLOSED)  
 FORM 14: T=TRACINGS ENCLOSED  
 LAB: P=PRELIMINARY RESULTS ENCLOSED, C=COMPLETED RESULTS ENCLOSED  
 MEDICAL RECORDS: P=PARTICIPANT, S=SPOUSE, C=CHILD (ENCLOSED)  
 DX=DIOXIN IM=IMMUNE

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	INITIALS:
DATE:						

PARTICIPANT LABEL

CASE NUMBER

GROUP NUMBER

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



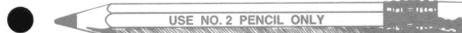
# FORM AFHS - JAS JENKINS ACTIVITY SURVEY

YEAR 15 FOLLOW UP

## MARKING INSTRUCTIONS

- Use No. 2 pencil only.
- Do not use ink or felt tip pens.
- Erase cleanly any mark you wish to change.
- Make solid marks that fill the circles completely.
- Make no stray marks on this form.

CORRECT MARK



INCORRECT MARKS



## AGE

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

1 (A) (B) (C)

16 (A) (B) (C) (D)

31 (A) (B) (C)

46 (A) (B) (C) (D)

2 (A) (B) (C)

17 (A) (B) (C) (D)

32 (A) (B) (C)

47 (A) (B) (C)

3 (A) (B) (C) (D)

18 (A) (B) (C) (D)

33 (A) (B) (C)

48 (A) (B) (C)

4 (A) (B) (C) (D) (E)

19 (A) (B) (C)

34 (A) (B)

49 (A) (B) (C)

5 (A) (B)

20 (A) (B) (C) (D)

35 (A) (B) (C)

50 (A) (B) (C) (D) (E)

6 (A) (B) (C) (D)

21 (A) (B) (C) (D)

36 (A) (B) (C)

51 (A) (B) (C) (D) (E) (F) (G) (H)

7 (A) (B) (C)

22 (A) (B) (C) (D)

37 (A) (B) (C)

52 (A) (B) (C)

8 (A) (B) (C)

23 (A) (B) (C) (D)

38 (A) (B) (C) (D)

9 (A) (B) (C)

24 (A) (B) (C) (D)

39 (A) (B)

10 (A) (B) (C)

25 (A) (B) (C) (D)

40 (A) (B) (C)

11 (A) (B) (C)

26 (A) (B) (C) (D)

41 (A) (B) (C)

12 (A) (B) (C)

27 (A) (B) (C)

42 (A) (B) (C) (D)

13 (A) (B) (C)

28 (A) (B) (C) (D)

43 (A) (B) (C) (D)

14 (A) (B) (C) (D)

29 (A) (B) (C)

44 (A) (B) (C) (D)

15 (A) (B) (C) (D)

30 (A) (B) (C)

45 (A) (B) (C) (D)

FORM QA AUDIT BY:

1 2 3 4 5 6 INITIALS:

DATE: