PULMONARY AIDS CLINICAL STUDY
FORM H - HOSPITAL FORM

Version Date: The version date of the form, located in the upper right corner of the form, should be checked by the interviewer to insure that the correct version of the form is being used.

1. **Patient ID:** The patient's ID label should be affixed here. If a label is not available, the ID should be printed neatly in the space provided.

2. **Clinic:** Enter the two digit clinic-specific ID number in the boxes provided. For all clinics that are composed of only one primary center, a '01' should be entered. If there is more than one clinic at a particular center, the investigator at the center should assign each clinic a different clinic ID number beginning with '01' and going in sequence. A list with the assigned clinic numbers should then be sent to the Coordinating Center.

3. **Date of Admission:** Enter the date that the patient was admitted to the hospital. Remember to use the date format described earlier in this document. This must be a complete date.

4. **Hospital:** Enter the name and address of the hospital where the patient has been admitted if not the study center.

5. **Reason for Admission:** Enter a check in the appropriate box designating whether the patient was admitted for a respiratory symptom or for other reasons. If for a reason other than a respiratory symptom, specify the reason in the space provided.

6. **Diagnosis:** For each diagnosis listed, place a check mark in the yes, no or don't know (DK) boxes indicating whether the diagnosis **was made during this hospitalization**. For affirmative diagnosis, check the appropriate box indicating whether pulmonary involvement was present. Finally, record the date of diagnosis using the date format specified earlier. If the complete date is not know, enter as much information as is

available and leave the unknown portion blank. Be sure to specify additional information where requested by printing the information in the space provided.

SPECIFIC DIAGNOSIS

a-d. Are **parasites** which can involve a variety of organ systems. If toxoplasmosis is diagnosed, indicate in the space provided if the toxoplasmosis involved the brain.

e-h. Are **fungal infections.** If candidiasis is diagnosed, indicate in the space provided if the candidiasis involved the esophagus.

i. Refers to disease/illness due to **tuberculosis.** In such cases treatment with multiple drugs will usually have been attempted or offered to the participant.

j. Refers to a variety of organisms similar to **M. tuberculosis** including **M. avium** and **M. kansasii.**

k. Refers to any illness caused by a **salmonella** infection.

l. Refers to any infection caused by this bacteria.

m. **Endocarditis** refers to a process (e.g., infection) involving the valves of the heart. By definition, this will not involve the pulmonary system.

n. Note any **other bacterial infection** and specify, if possible, the cause and part(s) to the body involved.

o-p. Enter responses regarding these **viruses.** If cytomegalovirus is diagnosed, indicate in the space provided if the cytomegalovirus involved the retina. Oral and genital herpes should be recorded separately.

q. **Shingles:** Diagnosis should include shingles only.

r. Record any **other virus** infection, excluding common cold, under other virus and specify, if possible, the specific virus and part(s) of the body involved.

s-t. Indicate responses for these specific types of **cancer**.

u. Note any other type of cancer specify, if possible, the organ of origin (leg, stomach, kidney, etc.) of the cancer.

v-kk. Will be assumed to involve (or note involve) the pulmonary system by definition. No entry re: pulmonary involvement should be entered for these items.

v. **LIP** a specific diagnostic entity.

w. Refers to a variety of ill defined entities.

x. Refers to blood clots involving any portion of the pulmonary circulation.

y. Refers to any kind of **congestive heart failure**.

z. Refers to any **injury of the chest or ribs**.

aa. ***Collapsed lung*** either spontaneous or traumatic.

bb. Any type of fluid collection about one or both lungs.

cc. Allergic, nonallergic or mixed at any time during the participant's life regardless of the degree of severity.

dd. **Cough** with sputum production occurring for a total of three or more months in any year.

ee. **Emphysema** diagnosed by any means.

ff. **Upper respiratory infection** refers to **any** condition, likely to be infection in origin involving the upper respiratory track including the sinuses and producing cough and/or nasal symptoms. Allergy symptoms should be excluded if possible.

mm. **Pneumonia**

gg. **Hepatitis** due to any cause.

hh. **Liver disease** other than hepatitis.

ii. **Diabetes** diagnosed by a physician.

jj. **Hemophilia** refers to one of several inherited abnormalities of blood coagulation. Other blood disease refers to any disorder, involving any blood cell line (red, white, or platelets) or coagulation (other than hemophilia).

kk. Specify any **other blood diseases** diagnosed by a physician.

ll. Other refers to any other diagnosis the participant offers that does not fit into one of the categories listed above. The diagnosis should be specified or described on the line(s) provided.

7. **Procedures/Diagnostic Tests:** For each procedure or diagnostic test listed, indicate whether the procedure was done during this hospitalization by checking the appropriate box. For each affirmative response, record the month and year that the procedure was performed. If the complete date is not remembered, enter as much information as possible and leave the unknown boxes blank. If other procedures were performed, enter them in the space provided and be sure to specify what these procedures were and when they were performed.

SPECIFIC PROCEDURES

a. **Sputum Induction:** Done for **any** reason or by any technique including inhaling mist by face mask or mouthpiece for the purpose of producing a sputum specimen.

b. **Chest X-ray:** Done for **any** reason including ***routine*** check-up within the past 2 years. For this response only, record the date that the chest X-ray was last performed instead of first performed.

c. **Bronchoscopy:** Either rigid or flexible inspection of the airways done for any indication.

d. **Transthoracic Needle Aspiration:** Insertion of a needle into the lung for the purpose of removing a specimen. This should be distinguished from thoracentesis.

e. **Thoracentesis:** Insertion of needle into through the chest wall and into the lining around the lung (pleura) usually for the purpose of removing fluid. Indicate yes if done for any reason.

f. **Pleural Biopsy:** Removal of a piece of membrane surrounding the lung. May be performed by a needle puncture of the chest wall (i.e., closed) or by a surgical procedure (i.e., open pleural biopsy). A ***closed*** biopsy may be performed with a thoracentesis.

g. **Thoracotomy:** Surgical incision into the chest. Indicate if done for any reason other than insertion of a drainage tube.

h. **Mediastinoscopy:** Surgical procedure for exploration of the central area within the chest cavity but external to the lungs. Typically performed to evaluate lymph nodes in that area. May be performed though an incision in the neck area (true mediastinoscopy). Answer yes if either procedure was ever performed.

i. **Lymph Node Biopsy:** Answer yes if any lymph node was removed (biopsy) or material removed by needle (aspiration) from any node on the body.

j. **Pulmonary Function Test:** Indicate yes if any PFT of any type ever performed.

k. **Gallium Scan:** Indicate Yes or No whether a Gallium Scan was performed.

l. **PPD:** Answer yes if a tuberculin skin test of any type has been received. Include skin infection (i.e., intradermal) and multiple puncture (Tine) tests.

m. **Other Procedures:** Specify any other procedures that have been performed on the study patient and the date they were performed.

8. **Intensive Care Unit:** Check the appropriate box indicating whether the patient was admitted to the intensive care unit. If so, indicate the number of days the patient was in the intensive care unit.

9. **Mechanical Ventilation Required:** Check the appropriate box indicating whether mechanical ventilation was required. If so, indicate the number of days that it was required.

10. **Discharge Status:** Indicate whether the patient was discharged alive from the hospital or died. If the patient died, indicate in Part A whether an autopsy was performed. If the patient was discharged alive, check the box indicating the patient's current disposition.

11. **Date of Discharge:** Record the date of discharge or death using the complete date format as specified earlier in the manual. If the patient died, indicate whether an autopsy was performed. If the patient was discharged alive, indicate by checking the appropriate box, the disposition of the patient.

Form Completed By: Indicate the name of the individual that completed the form.

Form Reviewer/Date: The individual, other than the interviewer, that reviews the form for completeness and correctness should print their name and the date the form was reviewed in a legible manner in the space provided.

Form Keyer/Date: The individual that keys the form using the RTIDE screen entry package should print their name and the date the form was keyed in a legible manner in the space provided.

FORM H

Version: 01 NOV 89

PULMONARY COMPLICATIONS OF HIV INFECTION
HOSPITAL FORM

1. Patient ID ..... [ ][ ][ ][ ][ ]

2. Clinic ..... [ ][ ]

Day Month Year

3. Date of Admission ..... [ ][ ] [ ][ ][ ] [ ][ ]

4. A. Name of Hospital, if not study center: _____

   B. Address: _____

5. Reason for Admission:

   [ ] Respiratory Symptom 01 [ ] Other, specify 02 _____

6. Were any of the following diagnoses made during this hospitalization?

KEYING INSTRUCTIONS: In keying the following section, key Y=Yes, N=No, U=DK

				Pulmonary Involvement			Date of DX		
	Yes	No	DK	Yes	No	DK	Day	Month	Year
A. Pneumocystis carinii	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]
B. Toxoplasmosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]
1. Of the Brain	[ ]	[ ]	[ ]						
C. Cryptosporidiosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]
D. Isosporiasis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]
E. Cryptococcosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]
F. Histoplasmosis	[ ]	[ ]	[ ]	[ ]	[ ]	[ ]	[ ][ ]	[ ][ ][ ]	[ ][ ]

	Yes	No	DK	Pulmonary Involvement Yes	No	DK	Date of DX Day	Month	Year
G. Coccidiomycosis	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
H. Candidiasis	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
1. Esophageal	☐	☐	☐	**If No, specify site:** _____					
I. Tuberculosis	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
J. Non-tuberculous mycobacteria	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
K. Salmonellosis	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
L. S.pneumoniae	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
M. Endocarditis	☐	☐	☐				☐☐	☐☐☐	☐☐
N. Other bacterial infection	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
Specify: _____									
O. Cytomegalovirus	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
1. Retinitis	☐	☐	☐						
P. Herpes Simplex 1. Oral	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
2. Genital/Rectal	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
Q. Shingles	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
R. Other Virus	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
Specify: _____									

	Yes	No	DK	Pulmonary Involvement Yes	No	DK	Date of DX Day	Month	Year
S. Kaposi's Sarcoma	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
T. Lymphoma	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
U. Other Cancer	☐	☐	☐	☐	☐	☐	☐☐	☐☐☐	☐☐
Specify Organ of Origin: _____									
V. Lymphoid Interstitial Pneumonitis	☐	☐	☐				☐☐	☐☐☐	☐☐
W. Nonspecific Interstitial Pneumonitis	☐	☐	☐				☐☐	☐☐☐	☐☐
X. Pulmonary Embolus	☐	☐	☐				☐☐	☐☐☐	☐☐
Y. Congestive Heart Failure	☐	☐	☐				☐☐	☐☐☐	☐☐
Z. Chest Injury/Rib Fracture	☐	☐	☐				☐☐	☐☐☐	☐☐
aa. Pneumothorax	☐	☐	☐				☐☐	☐☐☐	☐☐
bb. Pleural Effusion	☐	☐	☐				☐☐	☐☐☐	☐☐
cc. Asthma	☐	☐	☐				☐☐	☐☐☐	☐☐
dd. Bronchitis	☐	☐	☐				☐☐	☐☐☐	☐☐
ee. Emphysema	☐	☐	☐				☐☐	☐☐☐	☐☐
ff. Upper Respiratory Infection	☐	☐	☐				☐☐	☐☐☐	☐☐
mm. Pneumonia	☐	☐	☐				☐☐	☐☐☐	☐☐
gg. Hepatitis	☐	☐	☐				☐☐	☐☐☐	☐☐

	Yes	No	DK	Pulmonary Involvement Yes	No	DK	Date of DX Day	Month	Year
hh. Other Liver Disease	☐	☐	☐				☐☐	☐☐☐	☐☐
Specify: _____									
ii. Diabetes	☐	☐	☐				☐☐	☐☐☐	☐☐
jj. Hemophilia	☐	☐	☐				☐☐	☐☐☐	☐☐
kk. Other Blood Disease	☐	☐	☐				☐☐	☐☐☐	☐☐
Specify: _____									
ll. 1. Other	☐	☐		☐	☐	☐	☐☐	☐☐☐	☐☐
Specify: _____									
2. Other	☐	☐		☐	☐	☐	☐☐	☐☐☐	☐☐
Specify: _____									

7. Were any of the following procedures performed during this hospitalization?

	Yes	No	DK	DATE PERFORMED Month	Year
A. Sputum Induction	☐ y	☐ n	☐ u	☐☐☐	☐☐
B. Chest X-Ray	☐ y	☐ n	☐ u	☐☐☐	☐☐
C. Bronchoscopy	☐ y	☐ n	☐ u	☐☐☐	☐☐
D. Transthoracic Needle Aspiration	☐ y	☐ n	☐ u	☐☐☐	☐☐
E. Thoracentesis	☐ y	☐ n	☐ u	☐☐☐	☐☐
F. Pleural Biopsy	☐ y	☐ n	☐ u	☐☐☐	☐☐

	Yes	No	DK	DATE PERFORMED Month	Year
G. Thoracotomy	y	n	u		
H. Mediastinoscopy	y	n	u		
I. Lymph Node Biopsy	y	n	u		
J. Pulmonary Function Test	y	n	u		
K. Gallium Function Test	y	n	u		
L. PPD	y	n	u		
M. Other Procedures.....	y	n			
Specify: _____	y				
Specify: _____	y				
Specify: _____	y				

	Yes	No
8. Admission to intensive care unit	y	n
Number of Days		
9. Mechanical ventilation required	y	n
Number of Days		

10. Discharged

Alive	Died
01	02

	Yes	No
A. If DIED, was autopsy performed?.....	y	n

B. If discharged alive:

	Home	Hospital	Institution	Prison	Unknown
Disposition:	☐ 01	☐ 02	☐ 03	☐ 04	☐ 09

	Day	Month	Year
11. Date of discharge or death	☐☐	☐☐☐	☐☐

Hospital Form Completed By: _____

Form Reviewed By: _____ Date _____
(please print)

Form Keyed By: _____ Date: _____
(please print)