

# Patient Medical Form

## Patient Information

Patient ID: \_\_\_\_\_

Full Name: \_\_\_\_\_

Date of Birth (YYYY-MM-DD): \_\_\_\_\_

Gender: ☐ Male  
☐ Female  
☐ Other

Registration Date (YYYY-MM-DD) \_\_\_\_\_

## Contact Information

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_

Email: \_\_\_\_\_

## Clinical Details

Date Confirmed HIV Positive: \_\_\_\_\_

Previous ART Exposure: ☐ Yes  
☐ No

Current ART Regimen: \_\_\_\_\_

Start Date of Current ART: \_\_\_\_\_

## Clinical Visits and Monitoring

Date of First Visit: \_\_\_\_\_

Date of Most Recent Visit: \_\_\_\_\_

CD4 Count at First Visit: \_\_\_\_\_

Viral Load at First Visit: \_\_\_\_\_

CD4 Count at Most Recent Visit: \_\_\_\_\_

Viral Load at Most Recent Visit: \_\_\_\_\_

## Demographics and Risk Factors

Age at First Visit: \_\_\_\_\_

Employment Status:

- ☐ Employed
- ☐ Unemployed
- ☐ Student
- ☐ Retired
- ☐ Other (specify) \_\_\_\_\_

Education Level:

- ☐ Primary education
- ☐ Secondary education
- ☐ Tertiary education
- ☐ Other (specify) \_\_\_\_\_

Income Level:

- ☐ Low
- ☐ Medium
- ☐ High
- ☐ Prefer not to say

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Divorced
- ☐ Widowed
- ☐ Other (specify) \_\_\_\_\_

Substance Use History:

- ☐ None
- ☐ Alcohol
- ☐ Tobacco
- ☐ Illicit drugs
- ☐ Other (specify) \_\_\_\_\_

## Comorbidities and Symptoms

Comorbidities:

- ☐ Diabetes
- ☐ Hypertension
- ☐ Tuberculosis
- ☐ Hepatitis B/C
- ☐ Cardiovascular diseases
- ☐ Other (specify) \_\_\_\_\_

Reported Symptoms:

- ☐ Fever
- ☐ Weight loss
- ☐ Night sweats
- ☐ Cough
- ☐ Other (specify) \_\_\_\_\_

## Lifestyle Factors

Dietary Habits:

- ☐ Healthy
- ☐ Average
- ☐ Poor

Physical Activity:

- ☐ Regular
- ☐ Occasional
- ☐ None

## Medical Adherence

**Adherence to ART:**

- ☐ Always
- ☐ Often
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

**Missed Doses in the Last Month:** \_\_\_\_\_

**Adverse Event:**

- ☐ Yes (specify the event) \_\_\_\_\_
- ☐ No

## Calculated Information

**Duration of Follow-ups (in days):** \_\_\_\_\_

## Outcome Information

**Date of Exit from Study:** \_\_\_\_\_

**Reason for Exit:**

- ☐ Transferred out
- ☐ Died
- ☐ Lost to follow-ups
- ☐ Other (specify) \_\_\_\_\_

## Signature

**Doctor's Signature:** \_\_\_\_\_  
**Date:** \_\_\_\_\_