

**Neurocognitive Function Among HIV Infected Children On Protease Inhibitor Based Versus Non Protease Inhibitor Based Antiretroviral Therapy
Questionnaire Version 1.0
October 2018**

Study ID

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Complete this medical history and physical examination form at the enrolment of study participants.

PARTICULARS

1. Date of enrolment DD/MM/YR: ___/___/___	2. Child's Initials: _____	3. Sex: Male <input type="checkbox"/> Female <input type="checkbox"/>
4. Child's date of birth DD/MM/YR: ___/___/___	5. Child's Age (Completed years):	6. District of Residence:
7. Child's years of school (Completed years): _____ years	8. Caregiver's Relationship with child: _____	
9. Caregiver's Education level: None <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Don't know <input type="checkbox"/>		

PRESENT HEALTH HISTORY

10. Is the patient currently ill with any of the following symptoms: Fever, vomiting, severe diarrhoea, active convulsions, difficulty breathing, severe cough? N <input type="checkbox"/> Y <input type="checkbox"/>		
<i>If Y, send to Medical staff of JCRC for evaluation. If N, continue with enrolment</i>		
<u>HIV TREATMENT HISTORY</u>		
11. Child, combination:	PI-based <input type="checkbox"/>	Non-PI based <input type="checkbox"/>
12. Adherence: How many doses have you missed in the last 3 days? _____ doses		
13. ART initiation date DD/MM/YR: ___/___/___		
14. WHO clinical staging at ART initiation: I <input type="checkbox"/> II <input type="checkbox"/> III <input type="checkbox"/> IV <input type="checkbox"/>		
15. Is the child on O.I prophylaxis?	N <input type="checkbox"/>	Y <input type="checkbox"/>
16. If Y, list medications:		

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PAST MEDICAL HISTORY

Has the child:		
17. Any other medical condition apart from HIV?	N []	Y []
18. If yes list condition: _____		
19. Been hospitalized for malnutrition?	N []	Y []
20. Been hospitalized with coma?	N []	Y []
21. Been hospitalized meningitis?	N []	Y []
22. Been hospitalized with head injury?	N []	Y []
If Yes for any of the above conditions, exclude from the study.		
23. Been hospitalised for reasons other than those listed above?	N []	Y []
24. If yes, reason for the hospitalization: _____		

EARLY HEALTH HISTORY

25. Was child born before term?	N []	Y []
If yes;		
26. How many months early? _____ (completed) months		
27. Birth weight in kilograms? _____ Kg		
28. For how long was the child received breast fed? _____ (completed) months		

PHYSICAL EXAMINATION

29. Temp ____ . ____ ° C 30. Weight. ____ . ____ kg 31. Height. ____ cm.
 32. MUAC ____ . ____ cm

33. Is the child acutely ill by screening exam? N [] Y []

If yes:

Stop enrolment and refer to staff of JCRC for evaluation and treatment

GENERAL ASSESSMENT OF THE CHILD

34. General exam normal? N [] Y []

35. If no, describe: _____

36. Respiratory system normal? N [] Y []

37. If no, describe: _____

38. Cardiovascular system normal? N [] Y []

39. If no, describe: _____

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40. GIT system normal? N [] Y []

41. If no, describe: _____

42. CNS examination normal? N [] Y []

43. If no,
describe: _____

44. Other findings N [] Y []

45. *If yes*, describe: _____

NEURODEVELOPMENTAL SCREEN (TQQ)

46. Compared to other children, did your child delay in sitting, standing or walking?

N [] Y []

47. Compared to other children, does your child have difficulty seeing at night or during the day? N [] Y []

48. Does your child seem to have difficulties hearing?

N [] Y []

49. Does your child understand instructions?

N [] Y []

50. Does your child have any difficulty walking, moving his/her hands, weakness or stiffness in the hands and legs?

N [] Y []

51. Has your child ever had seizures or go into coma?

N [] Y []

52. Did your child learn how to do things at the same time as his/her age mates?

N [] Y []

53. Does your child speak?

N [] Y []

If Yes:

54. Does he/she speak clearly?

N [] Y []

55. Does he/she speak some things you can't understand at times?

N [] Y []

56. When compared to other children of his/her age, is his/her intelligence poorer, is he/she retarded or does he/she take long to understand?

N [] Y []

Done by _____

Date _____

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Neurocognitive Function Among HIV Infected Children On Protease Inhibitor Based Versus Non Protease Inhibitor Based Antiretroviral Therapy													
Social Economic Status Form (1 Page)													
Study ID: _ _ / _ _ / _ _ / _ _ / _ _		Date (DD/MM/YYYY): _ _ / _ _ / _ _ / _ _ / _ _ / _ _ / _ _ / _ _ / _ _											
EDUCATION													
1. Is the child currently in school?		<input type="checkbox"/> YES	<input type="checkbox"/> NO										
2. If YES, child is in school, what level?		<input type="checkbox"/> 0-none	<input type="checkbox"/> 1-preschool	<input type="checkbox"/> 2-nursery	<input type="checkbox"/> 3-P.1-P4	<input type="checkbox"/> 4-P.5-P7							
3. If NO, was child ever in school?		<input type="checkbox"/> YES	<input type="checkbox"/> NO										
4. If YES, child WAS in school, what level?		<input type="checkbox"/> 0-none	<input type="checkbox"/> 1-preschool	<input type="checkbox"/> 2-nursery	<input type="checkbox"/> 3-P.1-P.4	<input type="checkbox"/> 4-P.5-P7							
5. Who is the child's primary caregiver?		<input type="checkbox"/> Father	<input type="checkbox"/> Mother	<input type="checkbox"/> Other, specify _____									
6. Is child's mother able to read and write?		<input type="checkbox"/> YES	<input type="checkbox"/> NO										
7. What was the highest level of education for the child's primary care giver?		<input type="checkbox"/> 0-none	<input type="checkbox"/> 1-primary	<input type="checkbox"/> 2-secondary	<input type="checkbox"/> 3-tertiary								
8. Is child's father able to read and write?		<input type="checkbox"/> YES	<input type="checkbox"/> NO	<input type="checkbox"/> Don't know									
9. What was highest level of education for child's father?		<input type="checkbox"/> 0-none	<input type="checkbox"/> 1-primary	<input type="checkbox"/> 2-secondary	<input type="checkbox"/> 3-tertiary	<input type="checkbox"/> 4-don't know							
Socio-Economic Status													
1. How many siblings does this child have?													
<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> >12
2. How many people live under the same roof as this child?													

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<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5	<input type="checkbox"/> 6	<input type="checkbox"/> 7	<input type="checkbox"/> 8	<input type="checkbox"/> 9	<input type="checkbox"/> 10	<input type="checkbox"/> 11	<input type="checkbox"/> 12	<input type="checkbox"/> >12	
3. What type of roof do you have?				<input type="checkbox"/> 1-Thatch			<input type="checkbox"/> 2-Iron sheets		<input type="checkbox"/> 3-Tiles		<input type="checkbox"/> 4-Don't know			
4. What kind of water supply do you have?				<input type="checkbox"/> 1-Stream/pond/lake			<input type="checkbox"/> 2-Well		<input type="checkbox"/> 3-Borehole		<input type="checkbox"/> 4-Tap near or inside home			
5. What kind of cooking fuel do you use?				<input type="checkbox"/> 1-Firewood			<input type="checkbox"/> 2-Charcoal		<input type="checkbox"/> 3-Paraffin		<input type="checkbox"/> 4-Gas/Electricity			
6. Does the family eat meat at least once a week?				<input type="checkbox"/> YES			<input type="checkbox"/> NO							
7. Does the family have food all year round?				<input type="checkbox"/> YES			<input type="checkbox"/> NO							
8. Which of the following items are owned by you or found in your home? Add scores for YES responses for total														
Item				Score		Item				Score				
Electricity		<input type="checkbox"/> YES	<input type="checkbox"/> NO	3		Bicycle		<input type="checkbox"/> YES	<input type="checkbox"/> NO	1				
Shoes for subject		<input type="checkbox"/> YES	<input type="checkbox"/> NO	1		Motorcycle		<input type="checkbox"/> YES	<input type="checkbox"/> NO	2				
Radio		<input type="checkbox"/> YES	<input type="checkbox"/> NO	1		Motor vehicle		<input type="checkbox"/> YES	<input type="checkbox"/> NO	3				
Television		<input type="checkbox"/> YES	<input type="checkbox"/> NO	2		Animals (>2: cows, goats, pigs)		<input type="checkbox"/> YES	<input type="checkbox"/> NO	2				
						Poultry >10		<input type="checkbox"/> YES	<input type="checkbox"/> NO	2				
TOTAL (add scores from both columns of all YES responses)						_ _ / _ _								
MIGRATION														
In which district was the subject born?				District:										

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<i>Neurocognitive Function Among HIV Infected Children On Protease Inhibitor Based Versus Non Protease Inhibitor Based Antiretroviral Therapy</i>			
<i>In which district has the child lived for most of life?</i>	<i>District:</i>		
<i>In which district did the subject usually live for past 12 months?</i>	<i>District:</i>		
FORM COMPLETED BY:	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	SIGNATURE	<input type="text"/>
DATE (DD/MM/YYYY)	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		