

Patient identification code _____ Date of completion (dd/mm/yy) _____

Completed by _____

1. Have any of the following disease(s)/procedures been diagnosed/performed since D.A.D enrolment/ last follow-up*:

- a) Myocardial infarction (definitive/possible) Yes No If yes, date of diagnosis (mm/yy): _____
- b) Stroke Yes No If yes, date of diagnosis (mm/yy): _____
- c) Diabetes mellitus Yes No If yes, date of diagnosis (mm/yy): _____
- d) Coronary artery by-pass grafting Yes No If yes, date of procedure (mm/yy): _____
- e) Coronary angioplasty/stenting Yes No If yes, date of procedure (mm/yy): _____
- f) Carotid endarterectomy Yes No If yes, date of procedure (mm/yy): _____
- g) Non-AIDS defining cancer Yes No If yes, date of procedure (mm/yy): _____
- h) Chronic liver disease Yes No If yes, date of procedure (mm/yy): _____
- i) End-stage renal disease Yes No If yes, date of procedure (mm/yy): _____

* All diseases need to meet the criteria for the DAD events listed in the DAD MOOP and the New DAD Endpoint Guidelines

2. Have any first degree relatives (genetic mother, father, brother, sister) experienced myocardial infarction or stroke before the age of 50 years?

Yes No Unknown

3. Most recently measured:

	Not done	Fasting	Value	Unit	Date of measurement (mm/yy)
Serum total cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Serum HDL cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____
Serum triglycerides	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	_____

	Not done	Value	Date of measurement (dd/mm/yy)
4. Systolic and diastolic blood pressure	<input type="checkbox"/>	_____/____	_____

5. Ongoing treatment at time of this follow-up

	On treatment at current visit (Y=Yes, N=No, U=Unknown)	Start date (dd/mm/yy)	Stop date (dd/mm/yy)
a) Anti-platelets	<input type="checkbox"/>	_____	_____
b) ACE inhibitors	<input type="checkbox"/>	_____	_____
c) Antihypertensive agents, others	<input type="checkbox"/>	_____	_____
d) Lipid lowering agents	<input type="checkbox"/>	_____	_____
e) Oral antidiabetic agents	<input type="checkbox"/>	_____	_____
f) Insulin or derivatives hereof	<input type="checkbox"/>	_____	_____
g) Anabolic steroids/appetite stimulants	<input type="checkbox"/>	_____	_____

6. Is the patient currently a cigarette smoker Yes No Unknown

7. Is the patient experiencing loss of fat from extremities, buttocks or face? Yes No

8. Is the patient experiencing accumulation of fat in abdomen, neck, breasts or other defined location? Yes No