



# CRF 5 - ROUTINE FOLLOW-UP VISIT DURING TREATMENT

A1. Participant's ID number **C C C - C C C C**

A2. Center \_\_\_\_\_

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A2. Center \_\_\_\_\_

diating7drans2631 %wc

ecify \_\_\_\_\_

## CURRENT SYMPTOMS & PHYSICAL EXAM

Does the study participant have any of the following symptoms TODAY?

- Y1. Fever/Night sweats?                     NO    YES, (Y2) specify \_\_\_\_\_
- Y3. Weight loss without dieting?            NO    YES, (Y4) specify \_\_\_\_\_
- Y5. Cough?                                         NO    YES, (Y6) specify \_\_\_\_\_
- Y7. Sputum production?                       NO    YES,

