Form D2: Clinician-assessed Medical Conditions

CLEAR FORM

ADC name: _____ Subject ID: _ _ _ _ _ _ _ _ _ _ Form date: _ _ / _ _ / _ _ _ _

Visit #: _ _ _ Examiner's initials: _ _ _

INSTRUCTIONS: This form is to be completed by a physician, physician's assistant, nurse practitioner, or other qualified practitioner. For additional clarifications and examples, see UDS Coding Guidebook for Telephone Initial Visit Packet, Form D2.

Medical conditions and procedures

The following questions should be answered based on review of all available information, including new diagnoses made during the current visit, previous medical records, procedures, laboratory tests, and the clinical exam.

1. Cancer (excluding non-melanoma skin cancer), primary or metastatic

- ☐ 0 No **(SKIP TO QUESTION 2)**
- ☐ 1 Yes, primary/non-metastatic
- ☐ 2 Yes, metastatic
- ☐ 8 Not assessed **(SKIP TO QUESTION 2)**

1a. If yes, specify primary site: _____

If any of the conditions below are present (even if successfully treated), please check Yes.

2. Diabetes

- ☐ 0 No
- ☐ 1 Yes, Type I
- ☐ 2 Yes, Type II
- ☐ 3 Yes, other type (diabetes insipidus, latent autoimmune diabetes/type 1.5, gestational diabetes)
- ☐ 9 Not assessed or unknown

	No	Yes	Not assessed
3. Myocardial infarct	☐ 0	☐ 1	☐ 8
4. Congestive heart failure	☐ 0	☐ 1	☐ 8
5. Atrial fibrillation	☐ 0	☐ 1	☐ 8
6. Hypertension	☐ 0	☐ 1	☐ 8
7. Angina	☐ 0	☐ 1	☐ 8
8. Hypercholesterolemia	☐ 0	☐ 1	☐ 8
9. B12 deficiency	☐ 0	☐ 1	☐ 8
10. Thyroid disease	☐ 0	☐ 1	☐ 8

If any of the conditions below are present (even if successfully treated), please check Yes.

	No	Yes	Not assessed
11. Arthritis *If No or Not assessed,* **SKIP TO QUESTION 12** 11a. If yes, what type? ☐ 1 Rheumatoid ☐ 2 Osteoarthritis ☐ 3 Other (SPECIFY): _____ ☐ 9 Unknown 11b. If yes, regions affected (check at least one): 11b1. ☐ 1 Upper extremity 11b2. ☐ 1 Lower extremity 11b3. ☐ 1 Spine 11b4. ☐ 1 Unknown	☐ 0	☐ 1	☐ 8
12. Incontinence — urinary	☐ 0	☐ 1	☐ 8
13. Incontinence — bowel	☐ 0	☐ 1	☐ 8
14. Sleep apnea	☐ 0	☐ 1	☐ 8
15. REM sleep behavior disorder (RBD)	☐ 0	☐ 1	☐ 8
16. Hyposomnia/insomnia	☐ 0	☐ 1	☐ 8
17. Other sleep disorder 17a. (SPECIFY): _____	☐ 0	☐ 1	☐ 8
18. Carotid procedure: angioplasty, endarterectomy, or stent	☐ 0	☐ 1	☐ 8
19. Percutaneous coronary intervention: angioplasty and/or stent	☐ 0	☐ 1	☐ 8
20. Procedure: pacemaker and/or defibrillator	☐ 0	☐ 1	☐ 8
21. Procedure: heart valve replacement or repair	☐ 0	☐ 1	☐ 8
22. Antibody-mediated encephalopathy 22a. Specify antibody: _____	☐ 0	☐ 1	☐ 8
23. Other medical conditions or procedures not listed above 23a. (IF YES, SPECIFY): _____	☐ 0	☐ 1	