CAG Symptom-based Checklist

Name:		
CCC#:	Address:	Phone Number:
Current ARV Medications	_____ _____ _____ _____	
Other Medications /Supplies	☐ INH ☐ Cotrimoxazole ☐ Oral Contraception	☐ Condoms ☐ Other _____ _____
Review Check List	☐ Cough for > 2 weeks ☐ Night sweat > 2 weeks ☐ Weight loss ☐ Fever > 2 weeks ☐ Currently pregnant ☐ Fatigue/ breathless ☐ Has exposed infant ☐ Ankle swelling/ Puffiness of face	If yes to any of these refer to clinic for evaluation
New Medications prescribed since last drug pickup	☐ Yes ☐ No	If yes please specify _____ _____
Name/Signature of Person Completing form	Name: _____	Signature: _____