

NWTS LATE EFFECTS STUDY: PHYSICAL EXAMINATION

I. PATIENT NAME: _____ BIRTH DATE: _____ Patient ID #: _____
 Name of Physician Examining Patient: _____
 Address: _____
 Date of Exam: _____ Date/Cause of Death: _____

II. PHYSICAL FINDINGS: (Please indicate "ND" if not done)

Height (cm): _____ Weight (kg): _____ Blood Pressure: _____/_____

III TESTS ADMINISTERED: (Please indicate "ND" if a test was not done)

Chest X-ray: ()Not done ()Normal ()Abnormal (explain): _____
 Other Imaging: ()Not done ()Normal ()Abnormal (explain): _____
 Kidney Function: ()Not done ()Normal ()Abnormal (explain): _____
 Liver Function: ()Not done ()Normal ()Abnormal (explain): _____
 Cardiac Function: ()Not done ()Normal ()Abnormal (explain): _____

IV. PLEASE CHECK IF NORMAL AND DESCRIBE IF ABNORMAL. DO NOT LEAVE ANY CATEGORIES BLANK

SYSTEM	NORMAL	ABNORMAL	COMMENT
Hearing/Vision			
Skin/Hair/Nails			
Musculoskeletal			
Cardiovascular			
Pulmonary			
Gastrointestinal			
Hepatic			
Urinary (include infections)			
Neurologic			
Other (describe)			
Reproductive			

V. REPORT OF PREGNANCY IN NWTS PARTICIPANT OR PARTNER:

(In the instance of a multiple live birth please complete a report for each child)

Date Pregnancy Ended: _____ Duration (weeks): _____ Sex: _____ Weight: _____ Birth Order: _____

Outcome (e.g., single/multiple live birth, spontaneous abortion, please specify): _____

Note any complications or diseases during pregnancy: _____

Note any birth defects, diseases, or handicaps in the children: _____

Name of person completing form (please print): _____

SIGNATURE: _____ Date: _____
(Examining Physician)

Please mail the completed form to:
National Wilms Tumor Study, Fred Hutchinson Cancer Research Center
1100 Fairview Avenue N, M2-A876, P.O. Box 19024, Seattle, WA 98109
Telephone: (206) 667-4842, Message Line: (800) 553-4878, Fax: (206) 667-6623