NWTS LATE EFFECTS STUDY: PHYSICAL EXAMINATION

I. PATIENT NAME: ___________________________ BIRTH DATE: _________ NWTS # (if known): ________

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