



(affix label here)

Patient ID Number	Site	Sub-site	Sequential ID
<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>	<input style="width: 100%; height: 20px;" type="text"/>

SEARCH Physical Examination Form (to be completed for age 3 and older)

Anthropometric Measures	Examiner Code <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/>
<p>1. Height:</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> </div> <p style="text-align: center;"> First Second *Third </p> <p style="text-align: center;">*Third measurement required if first two measurements differ by >0.5 cm.</p> <p>2. Weight:</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> kg. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> kg. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> kg. </div> </div> <p style="text-align: center;"> First Second *Third </p> <p style="text-align: center;">*Third measurement required if first two measurements differ by >0.3 kg.</p> <p>If PATIENT is wearing a non-removable appliance, please specify the type of appliance. → <input style="width: 300px; height: 25px;" type="text"/></p> <p>3. Waist Circumference:</p> <p>3a. NHANES waist circumference:</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> </div> <p style="text-align: center;"> First Second *Third </p> <p style="text-align: center;">*Third measurement required if first two measurements differ by >1.0 cm.</p> <p>3b. Natural waist circumference:</p> <div style="display: flex; justify-content: space-around; align-items: flex-end;"> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> <div style="text-align: center;"> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> . <input style="width: 20px; height: 20px;" type="text"/> cm. </div> </div> <p style="text-align: center;"> First Second *Third </p> <p style="text-align: center;">*Third measurement required if first two measurements differ by >1.0 cm.</p>	

Public reporting burden of this collection of information is estimated to average 80 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC Reports Clearance Officer, 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; ATTN: PRA (0920-xxxx).

Blood Pressure		Examiner Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>																												
<p>4. Extremity: <i>(check one)</i> 1 <input type="checkbox"/> Right arm (preferred) 2 <input type="checkbox"/> Left arm</p> <p>5. Cuff size: <i>(check one)</i></p> <p>1 <input type="checkbox"/> Infant 2 <input type="checkbox"/> Child/Small Adult 3 <input type="checkbox"/> Adult 4 <input type="checkbox"/> Lg. Arm 5 <input type="checkbox"/> Thigh</p> <p>6. Pulse Disappearance Pressure: <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> mm. Hg</p> <p style="text-align: center;">+ 30</p> <hr style="width: 10%; margin: auto;"/> <p>7. Maximum inflation level (MIL): <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> <input style="width: 30px; height: 20px;" type="text"/> mm. Hg</p> <p>8. Blood Pressures:</p> <table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 15%;"></th> <th style="width: 15%; text-align: center;">Systolic</th> <th style="width: 10%; text-align: center;">/</th> <th style="width: 15%; text-align: center;">Diastolic</th> <th style="width: 45%;"></th> </tr> </thead> <tbody> <tr> <td>1st BP</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td style="text-align: center;">/</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td>mm. Hg.</td> </tr> <tr> <td>2nd BP</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td style="text-align: center;">/</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td>mm. Hg.</td> </tr> <tr> <td>3rd BP</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td style="text-align: center;">/</td> <td><input style="width: 30px; height: 20px;" type="text"/></td> <td>mm. Hg.</td> </tr> </tbody> </table> <p>8a. If unable to measure blood pressure, check reason:</p> <table style="width: 100%;"> <tr> <td>1 <input type="checkbox"/> Patient refused</td> <td>1 <input type="checkbox"/> Unable to determine MIL</td> </tr> <tr> <td>1 <input type="checkbox"/> Patient unable to sit</td> <td>1 <input type="checkbox"/> Unable to hear blood pressure sounds</td> </tr> <tr> <td>1 <input type="checkbox"/> Radial pulse not felt in either arm</td> <td>1 <input type="checkbox"/> Equipment malfunction</td> </tr> <tr> <td>1 <input type="checkbox"/> No cuff appropriate size</td> <td></td> </tr> </table>				Systolic	/	Diastolic		1 st BP	<input style="width: 30px; height: 20px;" type="text"/>	/	<input style="width: 30px; height: 20px;" type="text"/>	mm. Hg.	2 nd BP	<input style="width: 30px; height: 20px;" type="text"/>	/	<input style="width: 30px; height: 20px;" type="text"/>	mm. Hg.	3 rd BP	<input style="width: 30px; height: 20px;" type="text"/>	/	<input style="width: 30px; height: 20px;" type="text"/>	mm. Hg.	1 <input type="checkbox"/> Patient refused	1 <input type="checkbox"/> Unable to determine MIL	1 <input type="checkbox"/> Patient unable to sit	1 <input type="checkbox"/> Unable to hear blood pressure sounds	1 <input type="checkbox"/> Radial pulse not felt in either arm	1 <input type="checkbox"/> Equipment malfunction	1 <input type="checkbox"/> No cuff appropriate size	
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Acanthosis Nigricans		Examiner Code <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>
<p>9. Is Acanthosis Nigricans: <i>(check one)</i> 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Maybe</p>		

FOR STUDY USE ONLY									
Date Completed	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	Completed by	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
	Month	Day	Year			Code			
Date Reviewed	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	Reviewer Code	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
	Month	Day	Year						
Date Entered	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	Data Entry Code	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>	<input style="width: 20px; height: 20px;" type="text"/>
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