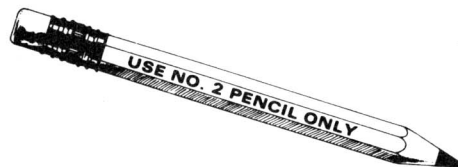


# FOLLOW-UP VISIT

## SECTION FOUR

ID NUMBER				VISIT NO.		TIME BEGAN				DATE			
						HR		MIN		JAN <input type="radio"/> DAY YR FEB <input type="radio"/> 8 MAR <input type="radio"/> 0 0 0 APR <input type="radio"/> 10 1 1 MAY <input type="radio"/> 20 2 2 JUN <input type="radio"/> 30 3 3 JUL <input type="radio"/> 4 4 4 AUG <input type="radio"/> 5 5 5 SEP <input type="radio"/> 6 6 6 OCT <input type="radio"/> 7 7 7 NOV <input type="radio"/> 8 8 8 DEC <input type="radio"/> 9 9 9			
0	0	0	0	0	0	0	0	0	0	<input type="radio"/>	a.m.		
1	1	1	1	1	1	10	1	10	1	<input type="radio"/>	p.m.		
2	2	2	2	2	2	2	20	2	20				
3	3	3	3	3	3	3	30	3	30				
4	4	4	4	4	4	4	40	4	40				
5	5	5	5	5	5	5	50	5	50				
6	6	6	6	6	6	6		6					
7	7	7	7	7	7	7		7					
8	8	8	8	8	8	8		8					
9	9	9	9	9	9	9		9					



- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make NO stray marks.
- Do NOT fold this form.

1. Let's start with a list of medical conditions. As I read each one, please tell me whether a doctor or other medical practitioner told you that you had it [since your visit in (MONTH)]. How about (EACH)? ([Since your visit in (MONTH)] Did a doctor or other medical practitioner say that you had that?)

- A. Kaposi's sarcoma or AIDS  
 B. Some form of cancer

NO	YES
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

IF "YES" TO CANCER:

a. In what month and year was it first diagnosed?

b. And what kind of cancer did they say it was?

Site: \_\_\_\_\_

MONTH	J	F	M	A	M	J	J	A	S	O	N	D
YEAR	83	84	85	86	87	88						

Diagnosed before 1984

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Type: \_\_\_\_\_

- C. Have you taken steroids or other drugs that suppress the immune system—not counting male sex hormones or anabolic steroids—for longer than two weeks (since your visit in (MONTH))?

NO	YES
<input type="radio"/>	<input type="radio"/>

IF "YES" TO D: For what condition (are you taking/did you take) (it/them)?

(SPECIFY) \_\_\_\_\_

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

- E. Not counting diagnostic dental x-rays or diagnostic x-rays of your lungs, bones, or other organs—did you have any radiation therapy or treatment [since your visit in (MONTH)]?

<input type="radio"/>	<input type="radio"/>
-----------------------	-----------------------

F.

MAKE NO STRAY MARKS

- G. Have you had diabetes diagnosed [since your visit in (MONTH)]?

IF "YES" TO DIABETES: In what month and year did it first start?

MONTH	J	F	M	A	M	J	J	A	S	O	N	D
YEAR	84	85	86	87	88							



DO NOT MARK IN THIS AREA

134230

1. Continued: How about (EACH)? Have you had that [since your visit in (MONTH)]?

NO YES

- H.
- I.
- J. Chronic kidney disease—not counting kidney stones  NO  YES
- K. Glomerulonephritis  NO  YES
- L. Systemic lupus erythematosus  NO  YES
- M. Vasculitis  NO  YES
- N. Rheumatoid arthritis  NO  YES
- O. Ankylosing spondylitis  NO  YES
- P. Reiter's syndrome  NO  YES
- Q. Thyroiditis or Graves' disease  NO  YES
- R. Myasthenia gravis  NO  YES
- S. Some other autoimmune disease  NO  YES

(SPECIFY)

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

2. A. [Since your visit in (MONTH)] Have you had

hemorrhoids or piles?

IF "YES": Have they bled since your visit in (MONTH)?

NO YES

<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

[Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

B. Shingles (or herpes zoster)

C. Bullous impetigo

D. Infectious mononucleosis

E. Jaundice or some liver disease other than hepatitis

<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

In which month (and year) (since your last visit) did this episode of shingles (zoster) begin?

Month		Year
Jan	Jul	85
Feb	Aug	86
Mar	Sep	87
Apr	Oct	88
May	Nov	89
Jun	Dec	

(SPECIFY)

	0	1	2	3	4	5	6	7	8	9
--	---	---	---	---	---	---	---	---	---	---

F. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had hepatitis or a blood test that was positive for hepatitis?

(1) IF HAD HEPATITIS: Can you tell me whether you had hepatitis A, infectious hepatitis, hepatitis B, serum hepatitis, non-A/non-B hepatitis, or didn't they say which kind it was? MARK ONE CODE FOR EACH IN FIRST SECTION.

(2) FOR EACH "YES": How did you happen to find out that you had (TYPE OF HEPATITIS) (IF DON'T KNOW WHICH KIND: some kind of hepatitis)—did you go to the doctor because you were feeling sick, did they happen to find it when they were doing a blood test for some other reason?

(1) HAD THIS TYPE? (2) HOW LEARNED?

NO, NOT THIS KIND YES, THIS KIND SYMP-TOMS BLOOD TEST

- Hepatitis A  NO  YES
- Infectious hepatitis  NO  YES
- Hepatitis B  NO  YES
- Serum hepatitis  NO  YES
- Non-A/non B-hepatitis  NO  YES

Other

	0	1	2	3	4	5	6	7	8	9
--	---	---	---	---	---	---	---	---	---	---

(SPECIFY)

Didn't say which kind it was.

NO YES

<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

3. Have you ever received an injection of hepatitis B vaccine?

IF "YES": Have you had it since your visit in (MONTH)?

MAKE NO STRAY MARKS

4.

**IF NEEDED, EXPLAIN:** By a "time" we mean each period when you thought it was cured and then it started again (or finally went away for good).

**ASK A FOR ALL BEFORE ASKING B FOR ANY.**

**A**

Have you had any of the following diseases or conditions [since your visit in (MONTH)]?

How about (EACH)?

**B**

And how many times have you had it [since your visit in (MONTH)]?

DISEASE OR CONDITION	HAD DISEASE		NUMBER OF TIMES
	NO	YES	
(1) Syphilis	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(2) Any form of gonorrhea <input type="text" value=""/> IF NO TO (2), SKIP TO (6)	<input type="radio"/>	<input type="radio"/>	
(3) Urethral gonorrhea (clap or drip of the urinary passage)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(4) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(5) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(6) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that's not caused by gonorrhea)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(7) Shigella, shigellosis, salmonella or salmonellosis	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(8) Amoebic dysentery	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(9) Giardia or giardiasis	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(10) Some other parasitic disease, such as worms.	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(11) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(12) Crabs (or lice)	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(13) Scabies	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>
(14) Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>

5.A. Have you had any of the following forms of herpes [since your visit in (MONTH)]?

NO YES

- 1) Facial herpes, cold sores, or fever blisters?  NO  YES
- 2) Sores in the genital region?  NO  YES
- 3) Sores in the anal or rectal area?  NO  YES

**IF "NO" TO ALL THREE, SKIP TO Q 6**

B. Did the first attack of herpes you ever had occur since your visit in (MONTH)?  NO  YES

C. Has there been a period [since your visit in (MONTH)] when your herpes sores seemed to come more often, get worse, or last longer?  
 No, not since visit in (MONTH)   
 Yes, that has happened

6. Within the past week have you had (EACH)?

NO YES

- A. A cold sore throat, sinus infections, or sinusitis  NO  YES
- B. A fever  NO  YES
- C. Influenza, flu, or bronchitis  NO  YES
- D. Diarrhea  NO  YES
- E. Hay fever  NO  YES
- F. An injury or some mechanical problem like a sprain, back pain, or stiff neck  NO  YES
- G. Some other illness that began in the last week  NO  YES

(SPECIFY)

7. [Since your visit in (MONTH)] Have you had any of the following problems or symptoms?

PROBLEM OR SYMPTOM FOR EACH "YES" IN <u>A</u> , ASK <u>B</u> , <u>C</u> , <u>D</u> , AND <u>E</u> .	A.		B.												C.		D.		E.				
	How about (EACH)? (Did you have that at any time [since your visit in (MONTH)]?)		In what month and year did it begin? [IF NEEDED: Even though you don't remember the exact month, it would help if you could tell me the season or approximate time of year when it started (this last time).]												Did that last for two weeks or longer?		Did that last for more than 30 days?		And do you still have that?				
	NO	YES	WHEN BEGAN (Month and Year)												NO	YES	NO	YES	NO	YES			
(1) Persistent shortness of breath for at least two weeks	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(2) A new or unusual kind of dry cough that lasted 2 weeks or longer	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(3) A persistent sore mouth or throat for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(4) Thrush, candida or white patches in your mouth or throat for at least two weeks	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(5) A new skin rash that lasted for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(6) An unusual bruise or bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(7) Persistent fatigue (feeling tired all the time) for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(8) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(9) Diarrhea for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(10) Persistent or recurring fever higher than 100° for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(11) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(12) Sweating at night for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(13) Persistent, frequent, or unusual kinds of headaches for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(14) Muscle or joint pains for at least 3 days	<input type="radio"/>	<input type="radio"/>	J	F	M	A	M	J	J	A	S	O	N	D	19	70	80	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8. A. At any time [since your visit in (MONTH)] did you stay overnight as a patient in a hospital?

- No →  Yes

**SKIP TO Q. 9**

IF "YES": How many separate times did you stay overnight as a patient in a hospital [since your visit in (MONTH)]?

		times
0	0	
10	1	
20	2	
30	3	
40	4	
50	5	
60	6	
70	7	
80	8	
90	9	



**NOTE ON BOOKMARK TO GET RELEASE OF RECORDS (AND NAME AND ADDRESS OF HOSPITAL)**

B. Tell me about (that hospitalization/each of those times).  
USE ONE COLUMN FOR EACH SEPARATE STAY SINCE VISIT IN (MONTH).

NOTES

	MOST RECENT HOSPITALIZATION			SECOND MOST RECENT HOSPITALIZATION		
	MONTH	DAY	YEAR	MONTH	DAY	YEAR
(1) On what date did you go into the hospital (the last time/the time before that)?	JAN	<input type="radio"/>		JAN	<input type="radio"/>	
	FEB	<input type="radio"/>	8	FEB	<input type="radio"/>	8
	MAR	<input type="radio"/>	0 0	MAR	<input type="radio"/>	0 0
	APR	<input type="radio"/>	10 1	APR	<input type="radio"/>	10 1
	MAY	<input type="radio"/>	20 2	MAY	<input type="radio"/>	20 2
	JUN	<input type="radio"/>	30 3	JUN	<input type="radio"/>	30 3
	JUL	<input type="radio"/>	4	JUL	<input type="radio"/>	4
	AUG	<input type="radio"/>	5	AUG	<input type="radio"/>	5
	SEP	<input type="radio"/>	6	SEP	<input type="radio"/>	6
	OCT	<input type="radio"/>	7	OCT	<input type="radio"/>	7
	NOV	<input type="radio"/>	8	NOV	<input type="radio"/>	8
	DEC	<input type="radio"/>	9	DEC	<input type="radio"/>	9
(2) How many nights did you spend in the hospital at that time?			nights			nights
		0 0			0 0	
		10 1			10 1	
		20 2			20 2	
		30 3			30 3	
		40 4			40 4	
		50 5			50 5	
		60 6			60 6	
		70 7			70 7	
		80 8			80 8	
(3) For what condition or problem were you hospitalized? RECORD FULLY IN R's OWN WORDS.						

(SPECIFY)

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

IF MORE THAN 2 HOSPITALIZATIONS SINCE VISIT IN (MONTH)  
↑ MARK HERE AND USE CONTINUATION SHEET.

9. A. Have you had a biopsy of lymph nodes or lymph glands [since your visit in (MONTH)]? (By a biopsy, we mean removal of at least one lymph node or lymph gland to study under the microscope.)

No → **SKIP TO Q. 10**  
 Yes

B. How many times did you have one [since your visit in (MONTH)]?

times

0
1
2
3
4
5
6
7
8
9



**NOTE ON BOOKMARK TO GET  
 RELEASE OF RECORDS  
 (AND NAME AND ADDRESS  
 OF HOSPITAL)**

C. And what did they say the diagnosis or result of the biopsy was?

(SPECIFY) \_\_\_\_\_

0	1	2	3	4	5	6	7	8	9
---	---	---	---	---	---	---	---	---	---

10. A. Have you received an injection or shot of gamma globulin [since your visit in (MONTH)]? (It's usually given in the buttocks to help protect you against hepatitis or to prevent other diseases—especially before you travel.)

No → **SKIP TO Q. 11**  
 Yes  
 Don't know → **SKIP TO Q. 11**

B. When was the last time?

MONTH	YEAR
JAN <input type="radio"/>	8
FEB <input type="radio"/>	
MAR <input type="radio"/>	0
APR <input type="radio"/>	1
MAY <input type="radio"/>	2
JUN <input type="radio"/>	3
JUL <input type="radio"/>	4
AUG <input type="radio"/>	5
SEP <input type="radio"/>	6
OCT <input type="radio"/>	7
NOV <input type="radio"/>	8
DEC <input type="radio"/>	9

11. A. Have you received a transfusion of blood or blood components (platelets or plasma) [since your visit in (MONTH)]?

- No → **SKIP TO Q. 12**  
 Yes  
 Don't know → **SKIP TO Q. 12**

B. When was the last time?

MONTH	YEAR
JAN <input type="radio"/>	8
FEB <input type="radio"/>	
MAR <input type="radio"/>	0
APR <input type="radio"/>	1
MAY <input type="radio"/>	2
JUN <input type="radio"/>	3
JUL <input type="radio"/>	4
AUG <input type="radio"/>	5
SEP <input type="radio"/>	6
OCT <input type="radio"/>	7
NOV <input checked="" type="radio"/>	8
DEC <input type="radio"/>	9

12. A. Not counting things like skin tests or injections of drugs, have you had any part of your body pierced—by acupuncture, by tattoo, or having your ears, nose or nipples pierced, or something like that [since your visit in (MONTH)]?

- No  
 Yes

13. Now I have some questions about cigarette smoking [since your visit in (MONTH)].

A. Do you smoke cigarettes now? (As of one month ago?)

- No → **SKIP TO C**  
 Yes  
 Occasionally (less than one cigarette per day) → **SKIP TO C**

B. How many packs do you usually smoke per day?

- Less than 1/2 pack a day  
 At least 1/2 pack, but less than one pack per day  
 At least 1 but less than 2 packs  
 2 or more packs per day

C. [Since your visit in (MONTH)] Has there been a change in your smoking habits?

- No, no change  
 Yes, increased or started  
 Yes, decreased or stopped

NOTES

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14. The next questions are about alcoholic beverages—that is, wine, beer or liquor you've drunk [since your visit in (MONTH)].

A. Please turn to page 1 in your booklet and tell me how often you have had a drink containing alcohol (a glass of beer, wine, a mixed drink, any kind of alcoholic beverage).

- At least once a day
- Nearly every day
- 3 or 4 times a week
- Once or twice a week
- 2 or 3 times a month
- About once a month
- 6–11 times a year
- 1–5 times a year
- Not at all

→ **SKIP TO D**

B. [Since your visit in (MONTH)] On days when you drank any alcoholic beverages, how many drinks did you usually have altogether? (By a drink we mean a can or glass of beer, a 4-ounce glass of wine, a 1 1/2-ounce shot of liquor, or a mixed drink with that amount of liquor.) Please turn to page 2 in your booklet for the possible answers to this.

- 1 or 2 drinks
- 3 or 4 drinks
- 5 or 6 drinks
- 7 or more drinks

C. [Since your visit in (MONTH)] What was the most that you had to drink in any given 24-hour period? Again, you'll find the answers to this on page 2 of your answer booklet.

- Never had more than usual
- 1 or 2 drinks
- 3 or 4 drinks
- 5 or 6 drinks
- 7 or 8 drinks
- 9–11 drinks
- 12 or more drinks

D. Have you changed the amount you drink [since your visit in (MONTH)]?

- No, no change
- Yes, increased or started
- Yes, decreased or stopped

NOTES



15. I'll be asking about recreational drug use later, but now I have some questions about drugs and medications that you may have taken for health reasons—either prescribed drugs or other things you took on your own [since your visit in (MONTH)].

How about any kinds of steroids—taken by mouth like cortisone or prednisone, or applied to the skin or other body surfaces or injected?

- Yes, used steroids—START WITH ITEM (1)
- No steroids—START WITH ITEM (4)

ASK A FOR ALL, BEFORE ASKING B–E FOR ANY. ASK B–E AS APPROPRIATE.

	A.		B.		C.		IF USED IN LAST 7 DAYS:		E.
	How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?		IF YES or uncertain: Did you take (THAT DRUG) as part of a research study in which you may have taken a placebo (not the actual drug)?		IF USED SINCE VISIT IN (MONTH): Have you (taken/used) (DRUG) in last 7 days?		D. How many days ago did you last take it, or did you take it today?		
	NO	YES	NO	YES	NO	YES	TODAY	DAYS AGO	
(1) Steroids that you took orally	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(2) Steroids that you applied to your body	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(3) Steroids that were injected	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(4) Some other kind of hormone such as anabolic steroids	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(5) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(6) Medication taken by mouth for fungal infection	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(7) Medication taken by mouth for worms or parasites	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(8) Anti-histamines, decongestants or other nose or throat medicine	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(9) Aspirin, Anacin, Bufferin or other similar medications	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(10) Some other kind of pain medicine, including Tylenol	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(11) Tranquilizers or sleeping pills	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(12) Antidepressants or mood elevators	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(13) Appetite suppressants or diet pills	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(14) Lithium	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
(15) Acyclovir (Zovirax)	<input type="radio"/>	Skip to C <input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	

16. (A.) Have you taken any medicine or drug on this list to help fight AIDS or the AIDS virus?

- Yes (HAVE PARTICIPANT READ/REVIEW WITH PARTICIPANT THE AIDS DRUG LIST—RECORD NAME OF DRUG TAKEN) (BE SURE TO ASK A, B, C, D, E QUESTIONS)
- No (SKIP TO Q 17)

<input type="radio"/>	0 100 200 300 400 500 600 700 800 900	<input type="radio"/> No	NO	YES	NO	YES	TODAY	DAYS AGO	
<input type="radio"/>	0 10 20 30 40 50 60 70 80 90	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
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<input type="radio"/>	0 100 200 300 400 500 600 700 800 900	<input type="radio"/> No	NO	YES	NO	YES	TODAY	DAYS AGO	
<input type="radio"/>	0 10 20 30 40 50 60 70 80 90	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
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<input type="radio"/>	0 10 20 30 40 50 60 70 80 90	<input type="radio"/> Yes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/> 1 <input type="radio"/> 2 <input type="radio"/> 3 <input type="radio"/> 4 <input type="radio"/> 5 <input type="radio"/> 6 <input type="radio"/> 7	
<input type="radio"/>	0 1 2 3 4 5 6 7 8 9	<input type="radio"/> Uncertain							

← MARK HERE IF YOU NEED TO USE CONTINUATION SHEET

16. (B.) Have you taken any substance at all (not on the list) to help fight AIDS or the AIDS virus?

No  
 Yes (GO TO E AND RECORD NAME)

		A. How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?	B. IF YES or uncertain: Did you take (THAT DRUG) as part of a research study in which you may have taken a placebo (not the actual drug)?		C. IF USED SINCE VISIT IN (MONTH): Have you (taken/used) (DRUG) in last 7 days?		IF USED IN LAST 7 DAYS: D. How many days ago did you last take it, or did you take it today?		E. What was the name of the (KIND OF DRUG) you took?						
			NO	YES	NO	YES	TODAY	DAYS AGO							
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17. Have you engaged in any sort of sexual activities, involving another person [since your visit in (MONTH)], any sort at all?

No → **ASK Q. 20C and Q. 20F. THEN ASK Q. 24**  
 Yes

18. A. [Since your visit in (MONTH)] Have you had some kind of sexual activity with another man?

No, not since visit in (MONTH)  
 Yes, since visit in (MONTH)

B. [Since your visit in (MONTH)] Have you had some kind of sexual activity with a woman?

No, not since visit in (MONTH)  
 Yes, since visit in (MONTH)

19. Which of these terms best describes your sexual behavior or activities [since your visit in (MONTH)]? Please refer to page 3 in the booklet.

- A —  Exclusively homosexual
- B —  Almost exclusively homosexual, but a small degree of heterosexual activity
- C —  Primarily homosexual, but with a substantial degree of heterosexual activity
- D —  Equally homosexual and heterosexual
- E —  Primarily heterosexual, but with a substantial degree of homosexual activity
- F —  Almost exclusively heterosexual, but a small degree of homosexual activity
- G —  Exclusively heterosexual

**IF EXCLUSIVELY HETEROSEXUAL (CODE G) READ THIS DEFINITION:** For the purposes of this study, sexual intercourse is defined as follows: You put your penis in your partner's mouth, vagina, or rectum. THEN SKIP TO Q20, asking for women only, and then skip to Q23.

**FOR ALL OTHERS, READ THIS DEFINITION:** For the purposes of this study, sexual intercourse is defined as follows: You put your penis in your partner's mouth, vagina, or rectum—or your partner put his penis in your mouth or rectum.



	A.	B.																																																												
21. The next questions are about the sexual practices some men engage in. Tell me the approximate number of (male) partners you did each activity with [since your visit in (MONTH)].  * IF NO INTERCOURSE, SKIP * ASTERISKED ITEMS.	<b>IF ANY SEX WITH MEN SINCE VISIT IN (MONTH):</b> How about (EACH)? How many men did you do that with [since your visit in (MONTH)]? (Give me the actual number) (IF NEEDED: What's your best estimate?) [If ONLY ONE PARTNER: Is that something you did with your partner [since your visit in (MONTH)]? (CODE 1 IF YES, 0 IF NO)  (CHECK BOOKMARK)	(Although you may have done this activity before) With how many of these men did you do this (engage in this activity) for the first time? [IF ONLY ONE PARTNER: Had you done that with him before? (CODE YES OR NO.)]  (CHECK BOOKMARK)																																																												
KIND OF ACTIVITY	NUMBER SINCE VISIT IN (MONTH)	NUMBER FIRST TIME																																																												
(1) You engaged in masturbation until your partner ejaculated/came	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(6) Thinking of the times you inserted your penis in your partner's rectum, (with how many of your partners) did you use a condom? * *	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(8) You inserted your finger or fingers (but not your whole hand) into your partner's rectum	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(10) He put his penis in your mouth * IF NONE, SKIP TO (12) *	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(12) He put his penis in your rectum IF NONE, SKIP TO (15) * *	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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KIND OF ACTIVITY	A. NUMBER SINCE VISIT IN (MONTH)										B. NUMBER FIRST TIME											
	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
(13) He ejaculated/came in your rectum	0	100	200	300	400	500	600	700	800	900		partners	0	100	200	300	400	500	600	700	800	
	0	10	20	30	40	50	60	70	80	90	0		10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> Yes, done before		<input type="radio"/> No, not done before									
(14) And thinking only of the times when your partner inserted his penis in your rectum, (how many of your partners used/did he use) a condom?	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(15) He used his tongue to touch or lick your anus or rectum ("rimming")	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(16) He put his finger or fingers into your rectum	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(17) He put his whole hand or fist into your rectum ("fisting")	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(18) He put a dildo or other device into your rectum	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(19) You engaged in water sports and were urinated on or drank your partner's urine	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(20) You engaged in deep, wet kissing, e.g., (where one of you put your tongue into the other's mouth)	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9		<input type="radio"/> Yes, done before	<input type="radio"/> No, not done before									
(21) And with how many partners did you use a douche or have an enema before having sex?	0	100	200	300	400	500	600	700	800	900	partners	0	100	200	300	400	500	600	700	800	900	partners
	0	10	20	30	40	50	60	70	80	90		0	10	20	30	40	50	60	70	80	90	
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22. How many times [since your visit in (MONTH)] have you noticed the following during or after sex?

A. You had bleeding around or from your anus or rectum

Never OR

0	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

times

B. Your (male) partner had bleeding around or from his anus or rectum

Never OR

0	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

times

IF NO SEX WITH WOMEN SINCE VISIT IN (MONTH)  
SKIP TO Q. 24

NOTES

23. Now some questions about sexual behavior with women. Tell me the approximate number of women you did each activity with [since your visit in (MONTH)].	A. <b>IF ANY SEX WITH WOMEN SINCE VISIT IN (MONTH):</b> How about (EACH)? How many women did you do that with [since your visit in (MONTH)]? (Give me the actual number.) (IF NEEDED: What is your best estimate?) (IF ONLY ONE PARTNER: Is that something you did with your partner [since your visit in (MONTH)]? (CODE 1 IF Yes, 0 IF NO))	B. (Although you may have done this activity before) With how many of these women did you do this (engage in this activity) for the first time? (IF ONLY ONE PARTNER: Had you done that with her before? (CODE YES OR NO.))																																																												
KIND OF ACTIVITY	NUMBER SINCE VISIT IN (MONTH)	NUMBER FIRST TIME																																																												
(1) Your partner masturbated you to the point of ejaculation (until you came)	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(4) You touched her clitoris with your tongue	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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(9) Thinking of all the times you had intercourse, (with how many of your partners) did you use a condom?	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners <input type="radio"/> Yes, done before <input type="radio"/> No, not done before	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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MAKE NO STRAY MARKS

24. Now let's talk about other drugs you may have used. As I read each one, please tell me whether you used it even once [since your visit in (MONTH)]?

ASK A FOR ALL BEFORE ASKING  
B-E FOR ANY

FOR EACH "YES" IN A, ASK  
B-E AS NEEDED

DRUG	A. How about (EACH)		B. How often did you (use/take) (DRUG) [since your visit in (MONTH)]? Refer to page 4 in your booklet.				
	NO	YES	DAILY	WEEKLY	MONTHLY	LESS	OFTEN
Marijuana or Hashish	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cocaine	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDA	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PCP, angel dust, psychedelics or hallucinogens like LSD, DMT or mescaline	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
"Downers", including barbiturates such as yellow jackets or reds, tranquilizers like Valium or Librium or other sedatives or hypnotics like Quaaludes	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ethyl chloride used as an inhalant	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin, Methadone or other opiates like Demerol	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Amphetamines, speed, crystal, or other "uppers"	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other kinds of street drugs	<input type="radio"/> Go to next row	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

MAKE  
NO  
STRAY  
MARKS

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**SPECIFY**

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	0	1	2	3	4	5	6	7	8	9

IF MORE THAN ONE "OTHER STREET DRUG" MARK HERE  AND USE CONTINUATION SHEET



C.		D.									E.				DRUG
Have you (used it/ taken any) within the last 7 days?		IF IN LAST 7 DAYS: How many days ago did you last use it, or was it today?									Have you (taken/used) (DRUG) with a needle [since your visit in (MONTH)]? [IF YES: Was that intravenous (or IV), intradermal or skin popping, or intramuscular?]				
NO	YES	T O D A Y	DAYS AGO							NO, NOT BY NEEDLE	INTRA- VENOUS	INTRA- DERMAL	INTRA- MUSCU- LAR		
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7					Marijuana etc.	
Next Row															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7					"Poppers"	
Next Row															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cocaine	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	MDA	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Psychedelics or hallucinogens	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	"Downers"	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7					Ethyl chloride	
Next Row															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Opiates	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	"Uppers"	
Go To E															
<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1	2	3	4	5	6	7	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Other	
Go To E															

NOTES

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24. A. Have you ever used/taken poppers or nitrite inhalants (amyl, butyl, or isopropyl nitrites)?

- No
- Yes

(1) IF YES, in what year did you first use poppers or nitrites?

19	10	20	30	40	50	60	70	80	
	0	1	2	3	4	5	6	7	8

(2) Beginning with 19\_\_ (YEAR FROM PREVIOUS QUESTION), during how many months altogether have you used/taken poppers or nitrites at least one time?

M O N T H S		0	100	200	300	400	500	600	700	800	900
		0	10	20	30	40	50	60	70	80	90
		0	1	2	3	4	5	6	7	8	9

(3) If we take an average month of use, for how many days (or nights) out of a possible 30 during the month would you use/take them?

D A Y S		0	10	20	30					
		0	1	2	3	4	5	6	7	8

25. How many times have you shared a needle with anyone [since your visit in (MONTH)]?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

26. Did you ever share a needle with someone who had or later developed AIDS?

- No, not to my knowledge
- Yes

NOTES


27. A. Have you ever been tested for the AIDS virus antibody outside of this study?

- No → **SKIP TO Q 28**
- Yes

B. Without telling me the results, have you received the results of any antibody test done outside of this study?

- No → **SKIP TO D**
- Yes

C. How many months ago did you last receive the results of any outside test for antibody?

- <6 months ago
- 6-12 months ago
- >12 months ago

D. Where was your most recent outside test performed?

- Through private physician's office
- Alternative test site
- Hospital
- Private laboratory
- Blood bank
- STD clinic
- Insurance company laboratory
- Other: \_\_\_\_\_  
(SPECIFY)

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

E. Why did you have your most recent outside test performed?  
(ANSWER ALL THAT APPLY)

- For purposes of another study
- For insurance purposes
- Because of known exposure to the virus
- To check for a change in your antibody status
- Because the U.S. Public Health Service recommended screening
- To check/confirm/refute the results given to you in this study
- For information to guide you in your current sexual relationship(s)
- For curiosity
- Because of symptoms
- Because it was required at your workplace
- Other:

\_\_\_\_\_  
(SPECIFY)

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

28. IF INTERVIEWING IN SAN FRANCISCO, OR LOS ANGELES, SKIP TO Q. 29 AT THE BOTTOM OF THE PAGE

ASK A FOR ALL,  
BEFORE ASKING  
B FOR ANY

	A.		FOR EACH "YES" ASK B	
	Tell me which of the following places you've been to [since your visit in (MONTH)]. How about (EACH)? (Have you been there [since your visit in (MONTH)]?)		B.  And about how many different sexual partners (if any) have you had in (EACH) [since your visit in (MONTH)]? (We mean people who were living in that area at the time).	
	BEEN THERE SINCE VISIT IN (MONTH)		PARTNERS SINCE VISIT IN (MONTH)	
	NO	YES		
(1) The New York City-Long Island-Newark Area	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(2) The San Francisco Bay Area	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(3) The Los Angeles Area	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(4) The Miami Area, including Fort Lauderdale and Key West	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(5) The Galveston-Houston Area	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(6) Haiti	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
(7) Zaire	<input type="radio"/>	<input type="radio"/>	<input type="text"/>	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

MAKE  
NO  
STRAY  
MARKS

29. A. So far as you know, did anyone that you ever had any sexual activity with get AIDS (either before or after your contact)?

- No, not to my knowledge → **SKIP TO Q. 30**
- Possibly, not certain
- Yes, definitely

B. How many got AIDS?

<input type="text"/>	<input type="text"/>
0	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

30. Now let's talk about changes in sexual practices. Please turn to page 5 in your booklet. As I read each one, please tell me whether it's something you've done since your visit in (MONTH), and if so, why.

How about (EACH)? (Is that something you've done in order to lower your risk of getting AIDS, something that's happened for some other reason, or something that did not happen?)

CHANGES IN SEXUAL PRACTICE	DID IT TO REDUCE RISK OF AIDS	HAPPENED FOR OTHER REASON (or just happened)	DID NOT HAPPEN
(1) Having fewer sexual partners than you used to have	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(2) Having fewer anonymous sexual partners	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(3) Increasing your use of condoms	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(4) Reducing your use of drugs with sex	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(5) <b>FOR PITTSBURGH, CHICAGO, AND BALTIMORE:</b> Having fewer (or no) partners from New York, San Francisco or Los Angeles	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(6) Changing the kinds of sexual practices you engage in	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(SPECIFY) _____ 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(SPECIFY) _____ 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(SPECIFY) _____ 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(SPECIFY) _____ 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(7) Any other changes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
(SPECIFY) _____ 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

31. A. Is there any aspect of your sexual experiences or anything more that I haven't asked about that you think we should know about?

- No, nothing more
- Yes

**THANK AND TERMINATE**

**SKIP TO Q 32**

B. Tell me about it. RECORD FULLY IN R'S OWN WORDS. CONTINUE ON BACK OF PAGE IF MORE SPACE NEEDED.

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32.

TIME ENDED			
HR		MIN	
0	0	0	0
10	1	10	1
	2	20	2
	3	30	3
	4	40	4
	5	50	5
	6		6
	7		7
	8		8
	9		9

a.m.

p.m.

33.

, 19

*Date interview completed*

34.

*Interviewer's signature*

**INTERVIEWER'S NUMBER**

0	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

**OFFICE USE ONLY**

0	0	0	0	0	0	0	0
1	1	1	1	1	1	1	1
2	2	2	2	2	2	2	2
3	3	3	3	3	3	3	3
4	4	4	4	4	4	4	4
5	5	5	5	5	5	5	5
6	6	6	6	6	6	6	6
7	7	7	7	7	7	7	7
8	8	8	8	8	8	8	8
9	9	9	9	9	9	9	9

MAKE NO STRAY

MARKS

ON THIS FORM

31.B R's Comments continued

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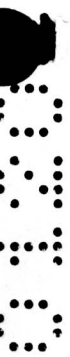


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**DO NOT ASK—INTERVIEWER OBSERVATIONS**



Other comments about interview or respondent—please write out below and, if necessary, continue on blank page.

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\_\_\_\_\_  
*Interviewer's signature*

