

SECTION 4



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

ID NUMBER				VISIT NO.				TIME BEGAN			DATE		
								HR	MIN		JAN	DAY	YR
0	0	0	0	0	0	0	0	0	<input type="radio"/>				
1	1	1	1	1	1	1	10	1	<input type="radio"/>				
2	2	2	2	2	2	2	2	2	<input type="radio"/>				
3	3	3	3	3	3	3	3	3					
4	4	4	4	4	4	4	4	4					
5	5	5	5	5	5	5	5	5					
6	6	6	6	6	6	6	6	6					
7	7	7	7	7	7	7	7	7					
8	8	8	8	8	8	8	8	8					
9	9	9	9	9	9	9	9	9					

DATE		
JAN	DAY	YR
<input type="radio"/>		
<input type="radio"/>		
<input type="radio"/>	0	0
<input type="radio"/>	10	1
<input type="radio"/>	20	2
<input type="radio"/>	30	3
<input type="radio"/>	4	4
<input type="radio"/>	5	5
<input type="radio"/>	6	6
<input type="radio"/>	7	7
<input type="radio"/>	8	8
<input type="radio"/>	9	9

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 ever told you that you had it. How about (EACH)? (Did a doctor or other medical practitioner say that you had that?)

IF "NO" TO a, GO TO NEXT ROW	a.	b. In what month and year was it first diagnosed?	c. How many times were you diagnosed with this? CODE "9" FOR 9 or MORE TIMES	d. Have you told us about all these times before?																								
A. Kaposi's sarcoma	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
B. Pneumocystis carinii pneumonia (PCP)	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
C. Toxoplasmosis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
D. Cytomegalovirus infection (CMV) Where was it? <input type="radio"/> Eyes <input type="radio"/> Lung <input type="radio"/> Colon <input type="radio"/> Other, specify: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
E. Mycobacterial infection (MAI or atypical TB)	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
F. Lymphoma, specify Type: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
G. Cryptococcal meningitis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
H. Candida in esophagus or lungs (not mouth)	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p>Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				1 2 3 4 5 6 7 8 9	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				

GET MEDICAL RELEASE

183252

DO NOT MARK IN THIS AREA

1. Continue

IF "NO" TO a, GO TO NEXT ROW	a.	b. In what month and year was it <u>first</u> diagnosed?	c. How many times were you diagnosed with this? CODE "9" FOR 9 or MORE TIMES	d. Have you told us about all these times before?																								
I. Cryptosporidiosis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
J. Wasting Syndrome	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
K. Any other AIDS diagnosis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
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83	84	85	86	87	88	89	90	91																				
1) Specify: <input style="width: 100%;" type="text"/>																												
Other AIDS diagnosis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
2) Specify: <input style="width: 100%;" type="text"/>																												
Other AIDS diagnosis	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
3) Specify: <input style="width: 100%;" type="text"/>																												
L. AIDS-related complex (ARC)	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				
M. AIDS related symptoms	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<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"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>	NO YES DK <input type="radio"/> <input type="radio"/> <input type="radio"/>
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J	F	M	A	M	J	J	A	S	O	N	D																	
83	84	85	86	87	88	89	90	91																				

N. Some other form of cancer NO YES

IF "NO," GO TO Q 2

<p>a. If yes, what kind of cancer did they say it was?</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 10%;">0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td> </tr> <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> <p>Site: <input style="width: 100%;" type="text"/></p> <p>Type: <input style="width: 100%;" type="text"/></p>	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	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	<p>b. On what month and year was it first diagnosed?</p> <table border="1" style="width: 100%; text-align: center;"> <tr> <td style="width: 12.5%;">J</td><td style="width: 12.5%;">F</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">M</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">J</td><td style="width: 12.5%;">A</td><td style="width: 12.5%;">S</td><td style="width: 12.5%;">O</td><td style="width: 12.5%;">N</td><td style="width: 12.5%;">D</td> </tr> <tr> <td>83</td><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="3"></td> </tr> </table> <p style="text-align: center;">↪ Diagnosed before 1984</p>	J	F	M	A	M	J	J	A	S	O	N	D	83	84	85	86	87	88	89	90	91				<p>c. Have you told us about this before?</p> <p style="text-align: center;"> NO YES DONT KNOW <input type="radio"/> <input type="radio"/> <input type="radio"/> </p>
0	1M	2M	3M	4M	5M	6M	7M	8M	9M																																																									
0	100	200	300	400	500	600	700	800	900																																																									
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83	84	85	86	87	88	89	90	91																																																										

GET MEDICAL RELEASE

GET MEDICAL RELEASE

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

NO YES

A. Shingles (or herpes zoster)

NO YES

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

MONTH	J	F	M	A	M	J	J	A	S	O	N	D
YEAR	83	84	85	86	87	88	89	90	91			

Diagnosed before 1984

NO YES

B. Bullous Impetigo

NO YES

C. Infectious mononucleosis

NO YES

D. Jaundice or some liver disease other than hepatitis

NO YES

E. Hepatitis or blood test that was positive for hepatitis?

NO YES

(1) IF HAD HEPATITIS: Can you tell whether you had hepatitis A, Infectious 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, or 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	SYMPTOMS	BLOOD TEST
Hepatitis A or Infectious hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Hepatitis B or serum hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Non-A/Non-B hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
OTHER	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Didn't say which kind it was.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Hepatitis A or Infectious hepatitis

Hepatitis B or serum hepatitis

Non-A/Non-B hepatitis

OTHER	Specify:
-------	----------

Didn't say which kind it was.

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

NO YES DON'T KNOW

If yes, when was the last time?

MONTH	J	F	M	A	M	J	J	A	S	O	N	D
YEAR	83	84	85	86	87	88	89	90	91			

before 1984

G. Have you received an injection of hepatitis B vaccine [since your last visit in (MONTH)]?

NO YES

H. Have you had a skin test for tuberculosis (PPD) [since your visit in (MONTH)]?

IF "YES": Was it positive?

NO YES

I. Were you diagnosed with tuberculosis [since you visit in (MONTH)]?

IF "YES": Was the tuberculosis OUTSIDE of the lung?

NO YES

J. [Since your visit (MONTH)] Has a doctor or other medical practitioner told you that you had oral hairy leukoplakia?

NO YES

K. Have you seen a doctor or other medical practitioner for any (other) condition [since your visit in (MONTH)]?

IF "YES": Was there a diagnosis for your condition?

NO YES

If "YES," what was the diagnosis?	
Specify:	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
Specify:	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
Specify:	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

GET MEDICAL RELEASE FORM

L. What service(s) have you used for your outpatient medical care [since your last visit (MONTH)]? ANSWER ALL THAT APPLY.

- None, did not receive outpatient care → **SKIP TO Q 3**
- Private doctor's office
- Private clinic, not hospital-based
- Private clinic, hospital-based
- Public clinic, not hospital-based
- Public clinic, hospital-based
- Hospital emergency room
- Other:

Specify:

M. How many times have you visited your outpatient medical care source [since your visit in (MONTH)]?

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

N. Have you received the following outpatient medical services [since your last visit in (MONTH)]? READ EACH TYPE OF SERVICE AND ASK "a." and "b."

Medical Service	a. Did you receive this service?	b. How many times [since your visit in (MONTH)] have you had this done in an outpatient setting? CODE "9" FOR 9 or MORE TIMES.
	NO YES	
1) Routine physical exam or check-up	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
2) Laboratory test	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
3) Therapy to prevent opportunistic infection (such as aerosolized pentamidine or amphotericin B)	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
4) Treatment of specific condition <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Specify condition and treatment:</div>	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
5) Other drug prescriptions	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
6) Counseling	<input type="radio"/> NEXT ROW <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)
7) Other <div style="border: 1px solid black; padding: 2px; margin-top: 5px;">Specify:</div>	<input type="radio"/> GO TO O <input type="radio"/>	(1) (2) (3) (4) (5) (6) (7) (8) (9)

O. What sources of payment did you use to cover the majority of costs for your outpatient medical care [since your visit in (MONTH)]?

- Not applicable, no medical care since visit
- Self-pay
- Blue Cross/Blue Shield (BC/BS)
- Private insurance, not BC/BS
- Health Maintenance Organization (HMO) member
- Medicaid
- Medicare
- Veteran's benefit
- Did not pay
- Other:

Specify:

3. 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 | <input type="radio"/> | <input type="radio"/> |
| 2) Sores in genital region | <input type="radio"/> | <input type="radio"/> |
| 3) Sores in the anal or rectal areas | <input type="radio"/> | <input type="radio"/> |
| 4) Sores elsewhere on your body | <input type="radio"/> | <input type="radio"/> |

IF "NO" TO ALL FOUR, SKIP TO Q. 4

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 last visit (MONTH)] when your herpes sores seemed to come more often, get worse or last longer than usual? NO YES

IF NEEDED EXPLAIN:

By "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. How many times have you had it [since your last visit in (MONTH)]?

DISEASE OR CONDITION	HAD DISEASE		NUMBER OF TIMES
	NO	YES	
(1) Syphilis	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(2) Any form of gonorrhea 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"/>	[1 2 3 4 5 6 7 8 9]
(4) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(5) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 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"/>	[1 2 3 4 5 6 7 8 9]
(7) Shigella, shigellosis, salmonella or salmonellosis	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(8) Amoebic dysentery	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(9) Giardia or giardiasis	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(10) Some other parasitic disease, such as worms	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(11) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(12) Crabs (or lice)	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]
(13) Scabies	<input type="radio"/>	<input type="radio"/>	[1 2 3 4 5 6 7 8 9]

5. [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. How about (EACH)? Did you have that at any time [since your visit in (MONTH)]?		b. Did that last for two weeks or longer?		c. And do you have that now?		d. Is this a new condition? IF NO, GO TO NEXT ITEM		e. In what month and year since your last visit 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).] WHEN BEGAN (Month and Year)
	NO	YES	NO	YES	NO	YES	NO	YES	
	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)								
(1) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(2) Diarrhea for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(4) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(5) Drenching sweats at night for at least 3 days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(6) Thrush, candida or white patches in your mouth or throat for at least two weeks	<input type="radio"/>	<input type="radio"/>	[Hatched Box]		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(7) An unusual bruise or bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>	[Hatched Box]		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)
(8) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>	[Hatched Box]		<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 19 0 1 2 3 4 5 6 7 8 9 (80 90)

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

- No → **SKIP TO Q. 7**
 Yes

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

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

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

6. Continued.

B. Tell me about (that hospitalization/each of those times) starting with the most recent hospitalization.

(1) a. On what date did you last go into the hospital? →

	J	F	M	A	M	J	J	A	S	O	N	D
	0	10	20	30								
	0	1	2	3	4	5	6	7	8	9		
	84	85	86	87	88	89	90	91				

b. How many nights did you spend in the hospital at that time? →

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

c. For what condition or problem were you hospitalized? RECORD FULLY IN R's OWN WORDS.

IF AIDS RELATED, CODE IN QUESTION 1 AS APPROPRIATE

d. In what type of hospital did your hospitalization take place?

- Private, for profit hospital
- Private, non-profit hospital
- Public hospital
- Other:

Specify:

Don't know

e. How did you pay for that hospitalization? ANSWER ALL THAT APPLY.

- Did not pay
- Medicare
- Self-pay
- Medicaid
- Self-pay with reimbursement
- Veteran's benefits
- Private insurance
- Other:
- Health Maintenance Organization (HMO) member

Specify:

f. Why did you use or choose this hospital? ANSWER ALL THAT APPLY.

- Accessibility (located close to home)
- Familiar with hospital
- Reputation for treating HIV-related problems
- Associated with AIDS-related clinical trials
- Doctor sent you there
- HMO sent you there
- Regular outpatient clinic is located there
- Veteran's status
- Ambulance brought you (no personal choice)
- Financial (restricted resources)
- Other:

Specify:

g. Did you have a prior hospitalization [since your visit in (MONTH)]?

- No → **SKIP TO Q. 7**
- Yes

(2) a. For your second most recent hospitalization, on what date did you go into the hospital?



	J	F	M	A	M	J	J	A	S	O	N	D
	0	10	20	30								
	0	1	2	3	4	5	6	7	8	9		
	84	85	86	87	88	89	90	91				

b. How many nights did you spend in the hospital at that time?



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

c. For what condition or problem were you hospitalized? RECORD FULLY IN R's OWN WORDS.

IF AIDS RELATED, CODE IN QUESTION 1 AS APPROPRIATE

d. In what type of hospital did your hospitalization take place?

- Private, for profit hospital
- Private, non-profit hospital
- Public hospital
- Other:

Specify:

Don't know

e. How did you pay for that hospitalization? ANSWER ALL THAT APPLY.

- Did not pay
- Medicare
- Self-pay
- Medicaid
- Self-pay with reimbursement
- Veteran's benefits
- Private insurance
- Other:
- Health Maintenance Organization (HMO) member

Specify:

f. Why did you use or choose this hospital? ANSWER ALL THAT APPLY.

- Accessibility (located close to home)
- Familiar with hospital
- Reputation for treating HIV-related problems
- Associated with AIDS-related clinical trials
- Doctor sent you there
- HMO sent you there
- Regular outpatient clinic is located there
- Veteran's status
- Ambulance brought you (no personal choice)
- Financial (restricted resources)
- Other:

Specify:

g. Did you have a prior hospitalization [since your visit in (MONTH)]?

- No → **SKIP TO Q. 7**
- Yes

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

7. A. [Since your visit in (MONTH)], have you had any biopsy? (By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

- No → **SKIP TO Q 8**
 Yes

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

times

C. For each biopsy, please tell me:

a. Site of biopsy	b. What did they say the diagnosis or result of the biopsy was?	c. Name of the doctor who performed the biopsy and where the biopsy was performed?
Specify: 0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor _____ Name of hospital/center/clinic _____ City _____ State _____
Specify: 0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor _____ Name of hospital/center/clinic _____ City _____ State _____
Specify: 0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor _____ Name of hospital/center/clinic _____ City _____ State _____

GET MEDICAL RELEASE

8. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes?

- No → **SKIP TO Q 9**
 Yes

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

- No → **SKIP TO Q 9**
 Yes → **SKIP TO D**
 Occasionally (less than one cigarette per day)

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

- Less than 1/2 pack
 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

D. [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

9. 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 to 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 all all

→ **SKIP TO Q. 10**

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 1½-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. [Since your visit in (MONTH)] Has there been a change in your drinking habits?

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

10. A. Now, without telling me your HIV antibody status, do you know what it is?

- No
- Yes

→ **SKIP TO Q. 11**

B. How many months ago did you LAST receive the results of ANY test for HIV antibody?

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

C. Were you ever tested for HIV antibody OUTSIDE of this study?

- No
- Yes

→ **SKIP TO Q. 11**

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?

- 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

11. Now, I have some questions about drugs and medications that you may have taken for health reasons not related to AIDS—either prescribed drugs or other things you took on your own [since your visit in (MONTH)].

Next I will ask you about medications for AIDS or HIV infection.

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEMS 12a-c)

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

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

	a. How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?		b. IF USED (SINCE VISIT IN (MONTH)): Have you (taken/used) (DRUG) in last 7 days?		IF USED IN LAST 7 DAYS:		d. What was the name of the (KIND OF DRUG) you took during the last 7 days?
	NO	YES	NO	YES	TODAY	DAYS AGO	
(1) Steroids that you took orally	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(2) Steroids that you applied to your body	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(3) Steroids that were injected	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(4) Some other kind of hormone such as anabolic steroids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(5) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(6) Medication taken by mouth for fungal infection	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(7) Medication taken by mouth for worms or parasites	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(8) Tranquilizers or sleeping pills	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(9) Antidepressants or mood elevators	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(10) Lithium	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(11) Acyclovir (Zovirax) for herpes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(12) a. Other (SPECIFY in column D)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(12) b. Other (SPECIFY in column D)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	
(12) c. Other (SPECIFY in column D)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	1 2 3 4 5 6 7	

12. Have you ever been enrolled in or taken part in a research study or clinical trial of drugs to help fight AIDS or the HIV virus, prevent or treat opportunistic infections or stimulate the immune system? No Yes → **GO TO Q. 15**

13. Have you ever considered participating in that kind of study? No → **GO TO Q. 16** Yes

14. Why did you choose not to participate? ANSWER ALL THAT APPLY.

- Tried to participate but not eligible
- Did not want placebo
- Side effect(s) of drug(s)
- Study center was inaccessible
- Too time consuming
- Did not feel well enough to participate
- Could get drug without being in study
- Felt healthy, drug not necessary
- Other:

Specify: _____

GO TO QUESTION 16

<p>a. Was this a placebo controlled study?</p> <p>(1)</p> <p>NO <input type="radio"/> YES <input type="radio"/></p> <p>DON'T KNOW <input type="radio"/></p>	<p>b. What is the name of the drug? CODE "999" FOR "DON'T KNOW."</p> <p>Name: _____</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px;">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>	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	<p>c. Was this part of the AIDS Clinical Trial Group (ACTG)</p> <p>NO <input type="radio"/> YES <input type="radio"/></p> <p>DON'T KNOW <input type="radio"/></p>	<p>d. What was the ACTG protocol number? CODE "999" FOR "DON'T KNOW."</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr><td style="width:20px;">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>	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	<p>e. Where were/are you enrolled in this study?</p> <p>Name of Center _____</p> <p>City _____</p> <p>State _____</p>
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<p>f. When did you start taking this drug? RECORD MONTH, DAY AND YEAR.</p>	<p>g. What dosage/amount of (THAT DRUG) do/did you take? CODE "9999" FOR "DON'T KNOW"</p>	<p>h. In what units? RECORD IN R'S WORDS. CODE "99" FOR "DON'T KNOW"</p>	<p>i. By what route do/did you take (THAT DRUG)? CODE "99" FOR "DON'T KNOW"</p>	<p>j. How often do/did you take it?</p>
<p>[]</p> <p>J F M A M J J A S O N D</p> <p>0 10 20 30</p> <p>0 1 2 3 4 5 6 7 8 9</p> <p>84 85 86 87 88 89 90 91</p>	<p>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</p> <p>0 100 200 300 400 500 600 700 800 900</p> <p>0 10 20 30 40 50 60 70 80 90</p> <p>0 1 2 3 4 5 6 7 8 9</p>	<p>0 10 20 30 40</p> <p>0 50 60 70 80 90</p> <p>0 1 2 3 4</p> <p>5 6 7 8 9</p>	<p>0 10 20 30 40</p> <p>0 50 60 70 80 90</p> <p>0 1 2 3 4</p> <p>5 6 7 8 9</p>	<p><input type="radio"/> Only took it once OR</p> <p>0 10 20 30 40 50 60 70 80 90</p> <p>0 1 2 3 4 5 6 7 8 9</p> <p><input type="radio"/> Day OR <input type="radio"/> Week OR <input type="radio"/> Month</p>
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<p>p. On what date did you restart taking this drug?</p>	<p>q. Did you take/use (DRUG) in last 7 days?</p>	<p>r. How many days ago did you last take it or did you take it today?</p>	<p>s. On a scale of 1 to 10 where 1 = "Did not follow study direction" and 10 = "Followed study directions completely" how would you rate your participation or compliance in that study?</p>	<p>t. How did you find out about this drug research study? MARK ALL THAT APPLY</p>
<p>[]</p> <p>J F M A M J J A S O N D</p> <p>0 10 20 30</p> <p>0 1 2 3 4 5 6 7 8 9</p> <p>84 85 86 87 88 89 90 91</p>	<p><input type="radio"/> No</p> <p>GO TO s</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7</p> <p>days ago</p>	<p>1 2 3 4 5 6 7 8 9 10</p>	<p><input type="radio"/> Friend</p> <p><input type="radio"/> Doctor</p> <p><input type="radio"/> Newspaper</p> <p><input type="radio"/> Television</p> <p><input type="radio"/> Other</p> <p>Specify: []</p>
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DO NOT MARK IN THIS AREA



15. Continued. [READ ACROSS PAGES 14 and 15]

No → **GO TO Q 16**

Did you participate in any other research study of a drug to help fight or prevent AIDS or the HIV-1 virus? Yes

<p>a. Was this a placebo controlled study?</p> <p>(3)</p> <p>NO <input type="radio"/> YES <input type="radio"/></p> <p>DONT KNOW <input type="radio"/></p>	<p>b. What is the name of the drug? CODE "999" FOR "DON'T KNOW."</p> <p>Name: _____</p> <table border="1" style="width: 100%; text-align: center;"> <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>	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	<p>c. Was this part of the AIDS Clinical Trial Group (ACTG)</p> <p>NO <input type="radio"/> YES <input type="radio"/></p> <p>DONT KNOW <input type="radio"/></p>	<p>d. What was the ACTG protocol number? CODE "999" FOR "DON'T KNOW."</p> <table border="1" style="width: 100%; text-align: center;"> <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>	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	<p>e. Where were/are you enrolled in this study?</p> <p>_____</p> <p>Name of Center</p> <p>_____</p> <p>City</p> <p>_____</p> <p>State</p>
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<p>k. What was the total number of (days/weeks/months) that you took the drug?</p> <p>(3)</p> <table border="1" style="width: 100%; text-align: center;"> <tr><td>0</td><td>0</td><td>0</td></tr> <tr><td>100</td><td>10</td><td>1</td></tr> <tr><td>200</td><td>20</td><td>2</td></tr> <tr><td>300</td><td>30</td><td>3</td></tr> <tr><td>400</td><td>40</td><td>4</td></tr> <tr><td>500</td><td>50</td><td>5</td></tr> <tr><td>600</td><td>60</td><td>6</td></tr> <tr><td>700</td><td>70</td><td>7</td></tr> <tr><td>800</td><td>80</td><td>8</td></tr> <tr><td>900</td><td>90</td><td>9</td></tr> </table> <p>Days <input type="radio"/> or Weeks <input type="radio"/> or Months <input type="radio"/></p>	0	0	0	100	10	1	200	20	2	300	30	3	400	40	4	500	50	5	600	60	6	700	70	7	800	80	8	900	90	9	<p>l. Did you stop/interrupt taking the drug?</p> <p>No <input type="radio"/></p> <p>GO TO q</p> <p>Yes <input type="radio"/></p>	<p>m. What was the reason(s)? MARK ALL THAT APPLY</p> <p><input type="radio"/> Study ended</p> <p><input type="radio"/> Became anemic</p> <p><input type="radio"/> Low white blood cells</p> <p><input type="radio"/> Dizziness/Headaches</p> <p><input type="radio"/> Bleeding</p> <p><input type="radio"/> Other side effects: _____</p> <p><input type="radio"/> Too much bother/Inconvenient</p> <p><input type="radio"/> Other: → _____</p> <p>Specify: _____</p> <p>Specify: _____</p>	<p>n. What was the date that you first stopped taking the drug?</p> <p>_____</p> <p>J F M A M J J A S O N D</p> <p>0 10 20 30</p> <p>0 1 2 3 4 5 6 7 8 9</p> <p>84 85 86 87</p> <p>88 89 90 91</p>	<p>o. Did you restart taking this drug?</p> <p>No <input type="radio"/></p> <p>GO TO s</p> <p>Yes <input type="radio"/></p>
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DO NOT MARK IN THIS AREA

15. Continued.

<p>f. When did you start taking this drug? RECORD MONTH, DAY AND YEAR.</p>	<p>g. What dosage/amount of (THAT DRUG) do/did you take? CODE "9999" FOR "DON'T KNOW"</p>	<p>h. In what units? RECORD IN R'S WORDS. CODE "99" FOR "DON'T KNOW"</p>	<p>i. By what route do/did you take (THAT DRUG)? CODE "99" FOR "DON'T KNOW"</p>	<p>j. How often do/did you take it?</p>																																																																																																																																																							
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<p>p. On what date did you restart taking this drug?</p>	<p>q. Did you take/use (DRUG) in last 7 days?</p>	<p>r. How many days ago did you last take it or did you take it today?</p>	<p>s. On a scale of 1 to 10 where 1 = "Did not follow study direction" and 10 = "Followed study directions completely" how would you rate your participation or compliance in that study?</p>	<p>t. How did you find out about this drug research study? MARK ALL THAT APPLY</p>																																																
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td colspan="8"></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><td colspan="2"></td></tr> <tr><td>84</td><td>85</td><td>86</td><td>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td colspan="4"></td></tr> </table>	J	F	M	A	M	J	J	A	S	O	N	D	0	10	20	30									0	1	2	3	4	5	6	7	8	9			84	85	86	87	88	89	90	91					<p><input type="radio"/> No</p> <p>GO TO s</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7</p> <p>days ago</p>	<p>1 2 3 4 5 6 7 8 9 10</p>	<p><input type="radio"/> Friend</p> <p><input type="radio"/> Doctor</p> <p><input type="radio"/> Newspaper</p> <p><input type="radio"/> Television</p> <p><input type="radio"/> Other</p> <p>Specify:</p> <div style="border: 1px solid black; height: 30px; width: 100%;"></div>
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16. Are you taking any drug/therapy to help fight AIDS or HIV infection that is not part of research study?

No (GO TO Q 17) Yes

a. Name of drug/therapy CODE "999" FOR "DON'T KNOW"	b. When did you start taking (THIS DRUG)?	c. What is the dose/amount of (THAT DRUG) that you take? CODE "9999" for "DON'T KNOW"	d. In what units? RECORD IN R'S WORDS. CODE "99" FOR "DON'T KNOW"
Name: <input type="text"/> <input type="radio"/> 0 <input type="radio"/> 100 <input type="radio"/> 200 <input type="radio"/> 300 <input type="radio"/> 400 <input type="radio"/> 500 <input type="radio"/> 600 <input type="radio"/> 700 <input type="radio"/> 800 <input type="radio"/> 900 <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9	<input type="text"/> <input type="radio"/> J <input type="radio"/> F <input type="radio"/> M <input type="radio"/> A <input type="radio"/> M <input type="radio"/> J <input type="radio"/> J <input type="radio"/> A <input type="radio"/> S <input type="radio"/> O <input type="radio"/> N <input type="radio"/> D <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9 <input type="radio"/> 84 <input type="radio"/> 85 <input type="radio"/> 86 <input type="radio"/> 87 <input type="radio"/> 88 <input type="radio"/> 89 <input type="radio"/> 90 <input type="radio"/> 91	<input type="text"/> <input type="radio"/> 0 <input type="radio"/> 1M <input type="radio"/> 2M <input type="radio"/> 3M <input type="radio"/> 4M <input type="radio"/> 5M <input type="radio"/> 6M <input type="radio"/> 7M <input type="radio"/> 8M <input type="radio"/> 9M <input type="radio"/> 0 <input type="radio"/> 100 <input type="radio"/> 200 <input type="radio"/> 300 <input type="radio"/> 400 <input type="radio"/> 500 <input type="radio"/> 600 <input type="radio"/> 700 <input type="radio"/> 800 <input type="radio"/> 900 <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9	<input type="text"/> <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9
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i. What were the reasons that you stopped/interrupted taking the drug? MARK ALL THAT APPLY.	j. What was the date you stopped taking DRUG?	k. Did you restart taking (THAT DRUG)?
<input type="radio"/> Became anemic <input type="radio"/> Low white blood cells <input type="radio"/> Bleeding <input type="radio"/> Dizziness/Headaches <input type="radio"/> Nausea/Vomiting <input type="radio"/> Other side effects, specify → <input type="text"/> <input type="radio"/> Too much bother, inconvenient <input type="radio"/> Other, specify → <input type="text"/>	<input type="text"/> <input type="radio"/> J <input type="radio"/> F <input type="radio"/> M <input type="radio"/> A <input type="radio"/> M <input type="radio"/> J <input type="radio"/> J <input type="radio"/> A <input type="radio"/> S <input type="radio"/> O <input type="radio"/> N <input type="radio"/> D <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9 <input type="radio"/> 84 <input type="radio"/> 85 <input type="radio"/> 86 <input type="radio"/> 87 <input type="radio"/> 88 <input type="radio"/> 89 <input type="radio"/> 90 <input type="radio"/> 91	<input type="radio"/> No (GO TO o) <input type="radio"/> Yes
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<input type="radio"/> Became anemic <input type="radio"/> Low white blood cells <input type="radio"/> Bleeding <input type="radio"/> Dizziness/Headaches <input type="radio"/> Nausea/Vomiting <input type="radio"/> Other side effects, specify → <input type="text"/> <input type="radio"/> Too much bother, inconvenient <input type="radio"/> Other, specify → <input type="text"/>	<input type="text"/> <input type="radio"/> J <input type="radio"/> F <input type="radio"/> M <input type="radio"/> A <input type="radio"/> M <input type="radio"/> J <input type="radio"/> J <input type="radio"/> A <input type="radio"/> S <input type="radio"/> O <input type="radio"/> N <input type="radio"/> D <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9 <input type="radio"/> 84 <input type="radio"/> 85 <input type="radio"/> 86 <input type="radio"/> 87 <input type="radio"/> 88 <input type="radio"/> 89 <input type="radio"/> 90 <input type="radio"/> 91	<input type="radio"/> No (GO TO o) <input type="radio"/> Yes

<p>e. By what route do/did you take (THAT DRUG)? CODE "99" FOR "DON'T KNOW"</p>	<p>f. How often do/did you take it?</p>	<p>g. What was the total number of (days/weeks/months) that you took drugs?</p>	<p>h. Did you stop/interrupt taking the drug?</p>
<p><input type="text"/></p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>	<p><input type="radio"/> Only took it once OR</p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p> <p>PER</p> <p><input type="radio"/> Day OR <input type="radio"/> Week OR <input type="radio"/> Month</p>	<p><input type="text"/></p> <p>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</p> <p><input type="radio"/> Days OR <input type="radio"/> Weeks OR <input type="radio"/> Months</p>	<p><input type="radio"/> No (GO TO m)</p> <p><input type="radio"/> Yes</p>
<p><input type="text"/></p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>	<p><input type="radio"/> Only took it once OR</p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p> <p>PER</p> <p><input type="radio"/> Day OR <input type="radio"/> Week OR <input type="radio"/> Month</p>	<p><input type="text"/></p> <p>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</p> <p><input type="radio"/> Days OR <input type="radio"/> Weeks OR <input type="radio"/> Months</p>	<p><input type="radio"/> No (GO TO m)</p> <p><input type="radio"/> Yes</p>
<p><input type="text"/></p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>	<p><input type="radio"/> Only took it once OR</p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p> <p>PER</p> <p><input type="radio"/> Day OR <input type="radio"/> Week OR <input type="radio"/> Month</p>	<p><input type="text"/></p> <p>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</p> <p><input type="radio"/> Days OR <input type="radio"/> Weeks OR <input type="radio"/> Months</p>	<p><input type="radio"/> No (GO TO m)</p> <p><input type="radio"/> Yes</p>
<p><input type="text"/></p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>	<p><input type="radio"/> Only took it once OR</p> <p>0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p> <p>PER</p> <p><input type="radio"/> Day OR <input type="radio"/> Week OR <input type="radio"/> Month</p>	<p><input type="text"/></p> <p>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</p> <p><input type="radio"/> Days OR <input type="radio"/> Weeks OR <input type="radio"/> Months</p>	<p><input type="radio"/> No (GO TO m)</p> <p><input type="radio"/> Yes</p>

<p>i. On what date did you restart taking this drug?</p>	<p>m. Did you take/ use (DRUG) in the last 7 days?</p>	<p>n. How many days ago did you last take it or did you take it today?</p>	<p>o. What is the name of the person following you and where is he/she located?</p>
<p><input type="text"/></p> <p>J F M A M J J A S O N D 0 10 20 30 0 1 2 3 4 5 6 7 8 9 84 85 86 87 88 89 90 91</p>	<p><input type="radio"/> No (GO TO o)</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7 days ago</p>	<p>NAME _____</p> <p>HOSPITAL/CLINIC _____</p> <p>CITY _____ STATE _____</p>
<p><input type="text"/></p> <p>J F M A M J J A S O N D 0 10 20 30 0 1 2 3 4 5 6 7 8 9 84 85 86 87 88 89 90 91</p>	<p><input type="radio"/> No (GO TO o)</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7 days ago</p>	<p>NAME _____</p> <p>HOSPITAL/CLINIC _____</p> <p>CITY _____ STATE _____</p>
<p><input type="text"/></p> <p>J F M A M J J A S O N D 0 10 20 30 0 1 2 3 4 5 6 7 8 9 84 85 86 87 88 89 90 91</p>	<p><input type="radio"/> No (GO TO o)</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7 days ago</p>	<p>NAME _____</p> <p>HOSPITAL/CLINIC _____</p> <p>CITY _____ STATE _____</p>
<p><input type="text"/></p> <p>J F M A M J J A S O N D 0 10 20 30 0 1 2 3 4 5 6 7 8 9 84 85 86 87 88 89 90 91</p>	<p><input type="radio"/> No (GO TO o)</p> <p><input type="radio"/> Yes</p>	<p><input type="radio"/> Today OR</p> <p>1 2 3 4 5 6 7 days ago</p>	<p>NAME _____</p> <p>HOSPITAL/CLINIC _____</p> <p>CITY _____ STATE _____</p>

17. A. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)], any sort at all (including deep kissing)?

- No → **SKIP TO Q. 24**
 Yes

B. [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)

C. [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)

READ DEFINITION OF INTERCOURSE:

IF EXCLUSIVELY HOMOSEXUAL READ THIS DEFINITION: I will also ask you about non-intercourse sexual activity, but for the purposes of this study, sexual intercourse is defined as follows: You put your penis in your partner's mouth, or rectum—or your partner put his penis in your mouth or rectum.

IF EXCLUSIVELY HETEROSEXUAL 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 Q. 18C asking for women only and then skip to Q. 24.

FOR ALL OTHERS, READ THIS DEFINITION: I will also ask you about non-intercourse sexual activity, but 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.

18. Now let's talk about the numbers of different people you have had sexual activity with [since your visit in (MONTH)].

MEN

A. With how many different men (if any) have you had sexual intercourse [since your last visit in (MONTH)]? READ DEFINITION OF INTERCOURSE.		<input type="radio"/> 0 <input type="radio"/> 100 <input type="radio"/> 200 <input type="radio"/> 300 <input type="radio"/> 400 <input type="radio"/> 500 <input type="radio"/> 600 <input type="radio"/> 700 <input type="radio"/> 800 <input type="radio"/> 900 <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9
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B. With how many other men have you had sexual activity that did <u>not</u> include intercourse?		<input type="radio"/> 0 <input type="radio"/> 100 <input type="radio"/> 200 <input type="radio"/> 300 <input type="radio"/> 400 <input type="radio"/> 500 <input type="radio"/> 600 <input type="radio"/> 700 <input type="radio"/> 800 <input type="radio"/> 900 <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9
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WOMEN

C. How many different women (if any) have you had sexual intercourse with [since your visit in (MONTH)]?		<input type="radio"/> 0 <input type="radio"/> 100 <input type="radio"/> 200 <input type="radio"/> 300 <input type="radio"/> 400 <input type="radio"/> 500 <input type="radio"/> 600 <input type="radio"/> 700 <input type="radio"/> 800 <input type="radio"/> 900 <input type="radio"/> 0 <input type="radio"/> 10 <input type="radio"/> 20 <input type="radio"/> 30 <input type="radio"/> 40 <input type="radio"/> 50 <input type="radio"/> 60 <input type="radio"/> 70 <input type="radio"/> 80 <input type="radio"/> 90 <input type="radio"/> 0 <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"/> 8 <input type="radio"/> 9
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If any intercourse or sexual activity with men since visit in (MONTH)

- and only 1 male partner since visit in (month), skip to Q. 20
- and more than 1 male sex partner since visit in (month), ask Q. 19
- if strictly heterosexual since visit in (month), skip to Q. 24

19. You mentioned that you had more than one male sexual partner [since your visit in (MONTH)]. Would you consider only one of these partners to be a steady partner or lover (in a primary relationship of 3 months or more)?

- No, skip to Q 21
- Yes, skip to Q 20B

20. You said you had (intercourse or sexual activity) with only one male partner [since your visit in (MONTH)].

A. How would you describe this individual?

- Steady partner/lover (in a primary relationship of 3 months or more)
- Friend/acquaintance
- Anonymous → **SKIP TO Q 21**

B. Do you know this partner's HIV antibody status?

- No
- Yes IF "YES": Is he...
 - Positive
 - Negative
 - Decline to answer

C. Has this partner had sexual activity with anyone other than you [since your visit in (MONTH)]?

- No, not to my knowledge
- Yes → **SKIP TO Q 21**
- Don't know → **SKIP TO Q 21**

D. How long have you and this sexual partner limited your sexual intercourse to each other exclusively?

ANSWER IN MONTHS OR YEARS

	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

Months

OR

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

Years

21. Of the (other) men you had sexual intercourse with [since your visit in (MONTH)] how many of them were more or less anonymous (that is you did not know how to find them again)?

	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

partners

22. The next questions are about the sexual practices some men engage in.
- IF ONLY ONE PARTNER SINCE LAST VISIT: USE COLUMN A.
- IF MULTIPLE PARTNERS SINCE LAST VISIT: USE COLUMN B.
- IF NO INTERCOURSE, SKIP ASTERISKED ITEMS.

KIND OF ACTIVITY	A. Did you do this/ engage in this activity with your partner since your last visit?	B. 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?)																														
1) You engaged in deep, wet kissing, e.g., (where one of you put your tongue into the other's mouth).	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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2) You engaged in masturbation until your partner ejaculated/came.	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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0	1	2	3	4	5	6	7	8	9																							
3) You put your penis in his mouth. * IF NONE, SKIP TO ITEM (5). *	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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4) You ejaculated/came into his mouth. *	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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5) You used your tongue to touch or lick his anus or rectum ("rimming").	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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6) You inserted your finger or fingers (but not whole hand) into your partner's rectum.	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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0	1	2	3	4	5	6	7	8	9																							
7) You put your whole hand or fist into his rectum ("fisting").	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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8) You used a douche or had an enema before having sex.	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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9) You put your penis into your partner's rectum * (anal insertive intercourse). * IF NONE, SKIP TO ITEM (15).	NO YES <input type="radio"/> <input type="radio"/>	NUMBER [SINCE VISIT IN (MONTH)] <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
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<p>IF MULTIPLE PARTNERS:</p> <p>10) With how many of those _____ partners had you used a condom every time even if it broke, tore or slipped? * IF ALL PARTNERS, SKIP TO ITEM (14). *</p> <p>IF ONE PARTNER:</p> <p>* Did you use a condom every time even if it broke, tore or slipped? *</p>	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 14	NUMBER [SINCE VISIT IN (MONTH)] <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
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0	10	20	30	40	50	60	70	80	90																							
0	1	2	3	4	5	6	7	8	9																							
<p>IF MULTIPLE PARTNERS:</p> <p>11) With how many of those _____ partners had you used a condom only some of the times? *</p> <p>IF ONE PARTNER:</p> <p>* Did you sometimes use a condom? *</p>	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 13	NUMBER [SINCE VISIT IN (MONTH)] <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
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																							
12) With how many of those _____ partners was a condom never used?		NUMBER [SINCE VISIT IN (MONTH)] <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
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0	10	20	30	40	50	60	70	80	90																							
0	1	2	3	4	5	6	7	8	9																							

22. Continued.

IF ONLY ONE PARTNER SINCE LAST VISIT: USE COLUMN A.

IF MULTIPLE PARTNERS SINCE LAST VISIT: USE COLUMN B.

IF NO INTERCOURSE, SKIP ASTERISKED ITEMS.

KIND OF ACTIVITY

IF MULTIPLE PARTNERS:

13) With how many of these partners when you did not use a condom, had you ejaculated/come in his rectum?

IF ONE PARTNER:

Did you ejaculate/come in his rectum when you did not use a condom?

A.

Did you do this/engage in this activity with your partner since your last visit?

NO YES

B.

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?)

NUMBER [SINCE VISIT IN (MONTH)]

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

NO YES

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

IF MULTIPLE PARTNERS:

21) How many of those _____ partners used a condom every time even if it broke, tore or slipped?
IF ALL SKIP TO ITEM (25)

IF ONE PARTNER:

Did he use a condom every time even if it broke, tore or slipped?

NO YES

SKIP TO ITEM 25

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

IF MULTIPLE PARTNERS:

22) How many of those _____ partners used a condom only some of the times?

IF ONE PARTNER:

Did he sometimes use a condom?

NO YES

SKIP TO ITEM 24

<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

23) How many of those _____ partners never used a condom?



<input type="text"/>	0	100	200	300	400	500	600	700	800	900	partners
<input type="text"/>	0	10	20	30	40	50	60	70	80	90	
<input type="text"/>	0	1	2	3	4	5	6	7	8	9	

22. Continued.

IF ONLY ONE PARTNER SINCE LAST VISIT: USE COLUMN A.

IF MULTIPLE PARTNERS SINCE LAST VISIT: USE COLUMN B.

IF NO INTERCOURSE, SKIP ASTERISKED ITEMS.

KIND OF ACTIVITY		A.	B.																																	
IF MULTIPLE PARTNERS: 24) * Of those _____ number of partners, who did not use a condom during anal receptive sex, how many ejaculated/came in your rectum? *		Did you do this/engage in this activity with your partner since your last visit? NO YES <input type="radio"/> <input type="radio"/>	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?) <table border="1"> <tr> <td></td> <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></td> <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></td> <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
	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 ONE PARTNER: * Did he ejaculate/come in your rectum when he did not use a condom? *																																				
IF MULTIPLE PARTNERS: 25) * How many partners had used a condom when it broke, tore or slipped and may have allowed semen to spill in your rectum? *		NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr> <td></td> <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></td> <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></td> <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
	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 ONE PARTNER: * Did he use a condom when it broke, tore or slipped? *																																				

23. How many times [since your visit in (MONTH)] have you noticed the following during or after sex?

A. You had cuts, sores, abrasions or bleeding on or from your penis.

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

B. Your partner had cuts, sores, abrasions or bleeding on or from his penis.

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

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

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

D. Your partner had bleeding around or from his anus or rectum.

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

24. 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 25**
- Possibly, not certain
- Yes, definitely

B. How many people got AIDS?

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

25. 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)]?

DRUG	A. How about (EACH) Have you (taken/used) any [Since your visit in (MONTH)]?		B. How often did you (use/take) (DRUG) [since your visit in (MONTH)]? Refer to page 5 in your booklet.				C. Have you (used it/taken any) within the last 7 days?		D. IF IN LAST 7 DAYS: How many days ago did you last use it, or was it today?							E. Did you (take/use) (DRUG) with a needle [since your visit in (MONTH)]?	
	NO <input type="radio"/> GO TO NEXT ROW	YES <input type="radio"/>	DAI LY	WEE KLY	MON THLY	LES S OFT EN	NO <input type="radio"/> NEXT ROW	YES <input type="radio"/>	T O D A Y	DAYS AGO						NO <input type="radio"/> NEXT ROW	YES <input type="radio"/>
Marijuana or Hashish	<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"/>	<input type="radio"/>	<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"/>	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack or cocaine that you smoke	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other forms of cocaine	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
MDA	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
PCP, angel dust, psychedelics, mushrooms or hallucinogens like LSD, DMT or mescaline	<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"/>	<input type="radio"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<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"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

↓

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

