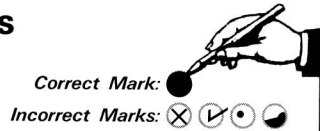


MARKING INSTRUCTIONS

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



ID NUMBER			
0	0	0	0
1	1	1	1
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VISIT NO.	
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DATE		
	DAY	YR
JAN		
FEB		
MAR	0	0
APR	10	1
MAY	20	2
JUN	30	3
JUL		4
AUG		5
SEP		6
OCT		7
NOV		8
DEC		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 <u>first</u> diagnosed?	c How many times were you diagnosed with this? FOR 9 OR MORE TIMES CODE "9"																										
A. Kaposi's sarcoma	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
B. Pneumocystis carinii pneumonia (PCP)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			1 2 3 4 5 6 7 8 9
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
C. Toxoplasmosis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
D. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it? CODE ALL THAT APPLY. (Do not code "YES" if only CMV antibodies.) <input type="radio"/> Eyes <input type="radio"/> Lung <input type="radio"/> Colon <input type="radio"/> Other (not blood) Specify: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			1 2 3 4 5 6 7 8 9
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
E. Mycobacterial infection (MAC, MAI or atypical TB)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
F. Lymphoma, specify <input type="radio"/> Primary brain lymphoma <input type="radio"/> Non-Hodgkin's <input type="radio"/> Other Specify: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
G. Cryptococcal meningitis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			
H. Candida in esophagus or lungs (not mouth)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr><td> </td><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> </td><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>92</td><td> </td><td> </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	92			
	J	F	M	A	M	J	J	A	S	O	N	D																	
	83	84	85	86	87	88	89	90	91	92																			

GET MEDICAL RELEASE

204194



1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b																								
		In what month and year was it first diagnosed?																								
I. Cryptosporidiosis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
	J	F	M	A	M	J	J	A	S	O	N	D														
	83	84	85	86	87	88	89	90	91	92																
J. Wasting Syndrome	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
	J	F	M	A	M	J	J	A	S	O	N	D														
	83	84	85	86	87	88	89	90	91	92																
K. Any other AIDS diagnosis	NO YES <input type="radio"/> <input type="radio"/> GO TO L	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
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	83	84	85	86	87	88	89	90	91	92																
1) Specify:	NO YES <input type="radio"/> <input type="radio"/> GO TO L	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
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	83	84	85	86	87	88	89	90	91	92																
Other AIDS diagnosis	NO YES <input type="radio"/> <input type="radio"/> GO TO L	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
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2) Specify:	NO YES <input type="radio"/> <input type="radio"/> GO TO L	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
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	83	84	85	86	87	88	89	90	91	92																
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	83	84	85	86	87	88	89	90	91	92																
3) Specify:	NO YES <input type="radio"/> <input type="radio"/> GO TO L	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
	J	F	M	A	M	J	J	A	S	O	N	D														
	83	84	85	86	87	88	89	90	91	92																

L. Some (other) form of cancer, excluding those mentioned above?

No Yes **IF "NO", GO TO Q 2**

a	b																																																																				
IF YES: What kind of cancer did they say it was?	In what month and year was it first diagnosed?																																																																				
1) Site: <table border="1"> <tr><td></td><td>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></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> Type:		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	<table border="1"> <tr> <td></td> <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></td> <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>92</td> </tr> </table> ↪ Diagnosed before 1984		J	F	M	A	M	J	J	A	S	O	N	D		83	84	85	86	87	88	89	90	91	92
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2.A. At any time [since your visit in (MONTH)] did you stay overnight as a patient in a hospital?

No → **SKIP TO Q 3**

Yes → How many separate times did you stay overnight as a patient in a hospital [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

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

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?

MO		J	F	M	A	M	J	J	A	S	O	N	D
DAY		0	10	20	30								
YR		84	85	86	87	88	89	90	91	92			

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

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

nights

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

GET MEDICAL RELEASE

IF ONLY ONE HOSPITALIZATION (SEE RESPONSE TO 2A), SKIP TO QUESTION 3

IF AIDS RELATED, CODE IN QUESTION 1 AS APPROPRIATE

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

MO		J	F	M	A	M	J	J	A	S	O	N	D		
DAY		0	10	20	30	0	1	2	3	4	5	6	7	8	9
YR		84	85	86	87	88	89	90	91	92					

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

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

nights

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

d. Did you have another prior hospitalization [since your last visit in (MONTH)]?

No → **SKIP TO Q 3**

Yes →

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

3.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 → **REVIEW RESPONSE TO Q 1, IF DIAGNOSED WITH CANCER, USE PROMPT AND REASK QUESTION, SKIP TO Q 4**

Yes

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

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

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?																																	
1)	Specify: _____ _____ <table border="1"><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>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	Specify: _____ _____ <table border="1"><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>		0	1	2	3	4	5	6	7	8	9	Name of doctor _____ Name of hospital/center/clinic _____ _____ City _____ State _____
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GET MEDICAL RELEASE

4. A. Have you ever received an injection of pneumococcal vaccine/Pneumovax? NO YES

B. Have you had any pneumonia other than PCP [since your visit in (MONTH)]? NO YES

IF YES:

Was it: → Viral
 (Read each type and mark all that apply.) Pneumococcal
 Other bacterial
 Other
 Specify:
 Don't know

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

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	92		

→ Diagnosed before 1984

B. Sinusitis NO YES

C. Bronchitis NO YES

D. Were you diagnosed with tuberculosis [since your visit in (MONTH)]? NO YES

→ **IF YES:** Was the tuberculosis OUTSIDE of the lung? NO YES

E. Have you had a skin test for tuberculosis (PPD) [since your visit in (MONTH)]? NO YES

→ **IF YES:** Was it positive? NO YES

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

F. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis]. NO YES

IF YES:

Was it: → Hepatitis A or infectious hepatitis
 (Read each type and mark all that apply.) Hepatitis B or serum hepatitis
 Non-A/Non-B hepatitis or hepatitis C
 OTHER
 Specify:
 Didn't say which kind it was

G. Have you received an injection of hepatitis B vaccine [since your last visit in (MONTH)]? NO YES

H. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had oral hairy leukoplakia? NO YES

5. I. [Since your visit in (MONTH)] Have you had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system? NO YES

IF YES: Was there a diagnosis for your condition? NO YES

IF YES: What was the diagnosis?

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

J. Have you seen a doctor or other medical practitioner for any (other) condition [since your visit in (MONTH)]? NO YES

IF YES: Was there a diagnosis for your condition? NO YES

IF YES: What was the diagnosis?

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

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

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

6. A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, [since your visit in (MONTH)]? NO YES

1) Facial herpes, cold sores, or fever blisters

2) Sores in genital region

3) Sores in the anal or rectal areas

4) Sores elsewhere on your body

IF "NO" TO ALL FOUR, SKIP TO Q. 7

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

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

	DISEASE OR CONDITION	HAD DISEASE	
		NO	YES
	1) Syphilis	<input type="radio"/>	<input type="radio"/>
<div style="border: 1px solid black; padding: 5px; width: fit-content;"> IF "NO" TO (2), SKIP TO (6) </div>	← 2) Any form of gonorrhea	<input type="radio"/>	<input type="radio"/>
	3) Urethral gonorrhea (clap or drip of the urinary passage)	<input type="radio"/>	<input type="radio"/>
	4) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>
	5) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>
	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"/>
	7) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>
	8) Molluscum contagiosum	<input type="radio"/>	<input type="radio"/>
	9) Any of the following: shigellosis, salmonellosis, amoebic dysentery, giardiasis or any other parasitic disease, including worms	<input type="radio"/>	<input type="radio"/>
		Specify: <input style="width: 100%;" type="text"/>	

8. [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> .	<u>a</u> How about (EACH)? Did you have that at any time [since your visit in (MONTH)]?		<u>b</u> Did that last for two weeks or longer?		<u>c</u> And do you have that now?		<u>d</u> Is this a new condition? IF NO, GO TO NEXT ROW		<u>e</u> 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)].	
	NO	YES	NO	YES	NO	YES	NO	YES	WHEN BEGAN (Month and Year)	
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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
2) A new skin condition or infection that lasted 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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
3) 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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
4) 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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
5) Tender or enlarged glands or lymph nodes (not counting your groin) 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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
6) Persistent, frequent or unusual kinds of headaches 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"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
7) Drenching sweats at night on at least 3 occasions	<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="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
8) Thrush, candida or white patches in your mouth or throat	<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="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	
9) An unusual bruise or bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>	/ / / / / / / / / /	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 83 84 85 86 87 88 89 90 91 92	

8. Continued.

PROBLEM OR SYMPTOM FOR EACH "YES" IN <u>a</u> , ASK <u>b</u> , <u>c</u> , <u>d</u> , AND <u>e</u> .	<u>a</u> How about (EACH)? Did you have that at any time [since your visit in (MONTH)]?		<u>b</u> Did that last for two weeks or longer?		<u>c</u> And do you have that now?		<u>d</u> Is this a new condition? IF NO, GO TO NEXT ROW		<u>e</u> 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)].
	NO	YES	NO	YES	NO	YES	NO	YES	
10) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<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 83 84 85 86 87 88 89 90 91 92
11) Burning, tingling or sensitivity in the feet 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 83 84 85 86 87 88 89 90 91 92
12) Aching or soreness in legs 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 83 84 85 86 87 88 89 90 91 92
13) Frequent tripping, stumbling or falling	<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 83 84 85 86 87 88 89 90 91 92
14) Difficulty getting up from a chair or toilet—needing to use your arms to pull up	<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 83 84 85 86 87 88 89 90 91 92
15) Difficulty in your hands, handling objects or with handwriting	<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 83 84 85 86 87 88 89 90 91 92
16) HIV-related symptoms or ARC <i>Specify:</i>	<input type="radio"/>	<input type="radio"/>	/						

9. Now I have some questions about cigarette smoking.

- A. Have you ever smoked cigarettes?
 No → **SKIP TO Q 10**
 Yes
- B. Do you smoke cigarettes now? (As of one month ago?)
 No → **SKIP TO Q 10**
 Yes
 Occasionally (less than one cigarette per day) → **SKIP TO Q 10**
- 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

10. 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 at all
 → **SKIP TO Q 11**
- 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

IF PARTICIPANT HAS HAD AN AIDS DIAGNOSIS, SKIP TO Q 12

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

- No
 Yes

12. Have you taken any medicine or drug to help fight AIDS or the HIV virus, prevent or treat opportunistic infections or stimulate the immune system?

No → **SKIP TO Q 13**
 Yes

A. (1) [Since your last visit (MONTH)] Have you taken any medication or drug on this list [SHOW LIST 1]?

No → **SKIP TO Q 12.B**
 Yes

(2) Please name those drugs that you have taken.

FILL IN THE CIRCLE NEXT TO THE DRUG(S).

- Acyclovir (ACV, Zovirax)
- AL-721
- Alpha Interferon
- Ampligen
- AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)
- Beta Interferon
- ddA (dideoxyadenosine)
- ddC (dideoxycytidine)
- ddI (dideoxyinosine, didanosine, videx)
- Dextran-Sulfate
- Foscarnet (Phosphonoformate, PFA)
- HPA-23
- Isoprinosine
- Peptide T
- Recombinant CD4
- Ribavirin
- Suramin
- Vidarabine (adenosine arabinoside)
- AZT/ddI trial
- AZT/ddC trial
- ddI/ddC trial
- AZT/ddI/ddC trial
- d4T
- Other anti-viral

specify:

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q. 12.A(2)

B. (1) [Since your visit in (MONTH)] Have you taken any medication or drug on this list [SHOW LIST 2] to help fight AIDS or the HIV virus, prevent or treat opportunistic infections, or stimulate the immune system?

No → **SKIP TO Q 12.C**
 Yes

(2) Please name the drugs you have taken. (RECORD EACH DRUG COMPLETELY AS STATED BY PARTICIPANT)

1. <input style="width: 100%;" type="text"/>	2. <input style="width: 100%;" type="text"/>	3. <input style="width: 100%;" type="text"/>																																																																																										
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COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q. 12.B(2)

C. (1) [Since your visit in (MONTH)] Have you taken any medication, drug or other therapy that was not listed to help fight AIDS or the HIV virus, prevent or treat opportunistic infections, or stimulate the immune system?

No → **SKIP TO Q 13**
 Yes

(2) Please name the other HIV related therapies you have taken.

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13. Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include either prescribed drugs or other things you took on your own [since your visit in (MONTH)].

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 10a)	a How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?	b What was the name of the (KIND OF DRUG) you took?				
IF "NO" TO a GO TO NEXT ITEM	FOR ITEMS 10a-c also ask: What did you take this drug for?					
1) Steroids that you took orally or were injected	<table border="0"> <tr> <td style="text-align: center;">NO</td> <td style="text-align: center;">YES</td> </tr> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	NO	YES	<input type="radio"/>	<input type="radio"/>	
NO	YES					
<input type="radio"/>	<input type="radio"/>					
2) Some other kind of hormone such as anabolic steroids, insulin or thyroxine	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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3) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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4) Medication taken by mouth for fungal infection	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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5) Medication taken by mouth for worms or parasites	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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6) Tranquilizers or sleeping pills	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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7) Antidepressants or mood elevators	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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8) Lithium	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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9) Acyclovir (Zovirax) for herpes	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> </table>	<input type="radio"/>	<input type="radio"/>			
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10) a. Other (SPECIFY in column b) _____ <table border="1" style="display: inline-table; vertical-align: middle;"> <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	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">SKIP TO Q 14</td> </tr> </table>	<input type="radio"/>	<input type="radio"/>	SKIP TO Q 14		Name: _____ Used for: _____
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c. Other (SPECIFY in column b) _____ <table border="1" style="display: inline-table; vertical-align: middle;"> <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	<table border="0"> <tr> <td style="text-align: center;"><input type="radio"/></td> <td style="text-align: center;"><input type="radio"/></td> </tr> <tr> <td colspan="2" style="text-align: center;">SKIP TO Q 14</td> </tr> </table>	<input type="radio"/>	<input type="radio"/>	SKIP TO Q 14		Name: _____ Used for: _____
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<input type="radio"/>	<input type="radio"/>																																			
SKIP TO Q 14																																				

14. Since your visit in (MONTH), have you used a therapeutic vaccine against HIV-1?
 No
 Yes

15. Since your visit in (MONTH), were you enrolled in a HIV-related vaccine trial?
 No
 Yes

16.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. 20**
 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 purpose 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. [Ask Q. 17A and B, DO NOT ask Q. 17C]
- IF EXCLUSIVELY HETEROSEXUAL, READ THIS DEFINITION:** For the purpose 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. 17C asking for women only and then skip to Q. 20.
- 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.

17. 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.		0	100	200	300	400	500	600	700	800	900	B. With how many other men have you had sexual activity that did not include intercourse?		0	100	200	300	400	500	600	700	800	900
		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			0	1	2	3	4	5	6	7	8	9

		WOMEN																	
C. With how many different women (if any), have you had sexual intercourse [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								

IF INTERCOURSE WITH ONLY ONE (1) PARTNER, ASK QUESTION 18, ELSE SKIP TO QUESTION 19.

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

- A. Do you know your partner's HIV antibody status?
 No Positive
 Yes **IF YES: Is he . . .** → Negative
 Decline to answer
- B. How would you describe this individual?
 Steady partner/lover (in a primary relationship of 3 months or more)
 Friend/acquaintance
 Anonymous → **SKIP TO Q. 19**
- C. Has this partner had intercourse or sexual activity with anyone other than you [since your visit in (MONTH)]?
 No, not to my knowledge
 Yes
 Don't know } → **SKIP TO Q. 19**

D. For how many months or years have you and this sexual partner had intercourse with only each other? (Code 1 month if less than 1 month.)

		MONTHS												YEARS											
		0	100	200	300	400	500	600	700	800	900		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			
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19. 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.**

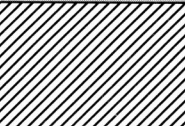
IF NO INTERCOURSE, SKIP ASTERISKED ITEMS.

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?)

KIND OF ACTIVITY																																
1) You masturbated your partner until your partner ejaculated/came.	NO YES <input type="radio"/> <input type="radio"/>	<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 put your penis in his mouth. * IF NONE, SKIP TO ITEM (4). *	NO YES <input type="radio"/> <input type="radio"/>	<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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3) You ejaculated/came into his mouth. * *	NO YES <input type="radio"/> <input type="radio"/>	<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 used your tongue to touch or lick his anus ("rimming").	NO YES <input type="radio"/> <input type="radio"/>	<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 put your penis into your partner's rectum (anal insertive intercourse). * IF NONE, SKIP TO ITEM (11).	NO YES <input type="radio"/> <input type="radio"/>	<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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IF MULTIPLE PARTNERS: 6) With how many of those ___ partners had you used a condom every time even if it broke, tore or slipped? * IF ONE PARTNER: * Did you use a condom every time even if it broke, tore or slipped?	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 10	<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 <div style="border: 1px solid black; padding: 5px; text-align: center;"> IF ALL PARTNERS, SKIP TO ITEM (10) </div>	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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IF MULTIPLE PARTNERS: 7) With how many of those ___ partners had you used a condom only some of the times? * IF ONE PARTNER: * Did you sometimes use a condom?	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 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	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) With how many of those ___ partners was a condom never used? *		<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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IF MULTIPLE PARTNERS: 9) 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?	NO YES <input type="radio"/> <input type="radio"/>	<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																							
IF MULTIPLE PARTNERS: 10) With how many partners had you used a condom when it broke, tore or slipped and may have allowed semen to spill into his rectum? * IF ONE PARTNER: * Did you use a condom when it broke, tore or slipped?	NO YES <input type="radio"/> <input type="radio"/>	<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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19. 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.

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

KIND OF ACTIVITY

ASK ITEMS (11, 12, AND 13) OF ALL NEW RECRUITS,
LOCAL OPTION TO ASK OF OTHERS

11) You put your whole hand or fist into his rectum ("fisting").	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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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12) You inserted your finger or fingers (but not whole hand) into your partner's rectum.	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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																								
13) You used a douche or enema before having sex.	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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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14) He put his penis in your mouth. * IF NONE, SKIP TO ITEM (16) *	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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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15) He ejaculated/came into your mouth. * *	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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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16) He used his tongue to touch or lick your anus ("rimming").	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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																								
17) He put his penis in your rectum (anal receptive intercourse). * IF NONE, SKIP TO ITEM (23) *	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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																								
IF MULTIPLE PARTNERS: 18) How many of those ___ partners used a condom <u>every</u> time even if it broke, tore or slipped? * IF ONE PARTNER: * Did he use a condom <u>every</u> time even if it broke, tore or slipped? *	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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 <div style="border: 1px solid black; padding: 5px; text-align: center;"> IF ALL, SKIP TO ITEM (22) </div>	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																								
IF MULTIPLE PARTNERS: 19) How many of those ___ partners used a condom <u>only</u> some of the times? * IF ONE PARTNER: * Did he sometimes use a condom? *	NO <input type="radio"/>	YES <input type="radio"/>	<table border="1" style="width: 100%;"> <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 <div style="text-align: center;"> SKIP TO ITEM 21 </div>	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																								
20) How many of those ___ partners <u>never</u> used a condom? *			<table border="1" style="width: 100%;"> <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																								

19. 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.

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?)

KIND OF ACTIVITY		a	b																																	
IF MULTIPLE PARTNERS: 21) Of those ___ number of partners, who did not use a condom during anal receptive sex, how many * ejaculated/came in your rectum? IF ONE PARTNER: * Did he ejaculate/come in your rectum when he did not use a condom?		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
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	0	10	20	30	40	50	60	70	80	90																										
	0	1	2	3	4	5	6	7	8	9																										
IF MULTIPLE PARTNERS: 22) How many partners had used a condom when it broke, * tore or slipped and may have allowed semen to spill in * your rectum? IF ONE PARTNER: * Did he use a condom when it broke, tore or slipped?		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
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	0	1	2	3	4	5	6	7	8	9																										
ASK ITEMS 23 AND 24 OF ALL NEW RECRUITS, LOCAL OPTION TO ASK OF OTHERS																																				
23) He put his whole hand or fist into your rectum? ("fisting").		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
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	0	10	20	30	40	50	60	70	80	90																										
	0	1	2	3	4	5	6	7	8	9																										
24) He put his finger or fingers (but not his whole hand) into 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
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	0	1	2	3	4	5	6	7	8	9																										

20. 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)]?

	a	b				c	
	How about (EACH) Have you (taken/used) any [since your visit in (MONTH)]?	How often did you (use/take) (DRUG) [since your visit in (MONTH)]? Refer to page 5 in your booklet.				Did you (take/use) (DRUG) with a needle [since your visit in (MONTH)]?	
		DAILY	WEEKLY	MONTHLY	LESS OFTEN		
Marijuana or hashish	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	[Hatched Area]	
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Crack or cocaine that you smoke	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other forms of cocaine	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other kinds of drugs	NO YES <input type="radio"/> <input type="radio"/> GO TO Q. 21	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	NO YES	<input type="radio"/> <input type="radio"/>

Specify:

We would now like to ask you about your medical coverage.

21. A. Since your last visit did you have . . .
[ASK EACH ITEM AND RECORD ANSWER]

	NO	YES
1) Coverage by an HMO	<input type="radio"/>	<input type="radio"/>
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)	<input type="radio"/>	<input type="radio"/>
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)	<input type="radio"/>	<input type="radio"/>
4) Medicaid, Medi-Cal, or Medical Assistance	<input type="radio"/>	<input type="radio"/>
5) Medicare (for people over 65 or permanently disabled)	<input type="radio"/>	<input type="radio"/>
6) Health care benefits for The Armed Forces or Veteran's Administration	<input type="radio"/>	<input type="radio"/>
7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans.	<input type="radio"/>	<input type="radio"/>
8) Other	<input type="radio"/>	<input type="radio"/>

Specify:

<input type="text"/>	0	1	2	3	4	5	6	7	8	9
----------------------	---	---	---	---	---	---	---	---	---	---

IF NO TO (1) - (8), SKIP TO E

B. 1) Did you or other personal sources (such as friends, lovers, relatives) contribute to the cost of your health insurance premiums?

No Yes

2) **IF YES:** How much did you or these other sources contribute to health insurance premiums since your last visit?

[ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN \$1]

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

OR Don't Know Refused

C. [IF YES TO PRIVATE OR OTHER INSURANCE (Q 21.A. 1), 2), 3) OR 8)], ASK:]

NO YES

1) Does your employer pay all or part of the cost of your health insurance premiums?

2) Do you have COBRA benefits, that is, have you stopped working but remained part of your employer group health insurance plan?

3) **IF YES:** Does the state pay any of the cost of the COBRA health insurance premium?

D. Did you lose private health insurance coverage at any time since your last visit, even temporarily?

E. 1) Have you applied for private health insurance at any time since your last visit?

2) **IF YES:** Have you been refused health insurance coverage at any time since your last visit?

22. Did you have any type of dental insurance coverage at any time since your last visit in (MONTH)?

No Yes

23. Where do you usually go for medical care, even if you haven't received medical care since your last visit? [READ ALL CHOICES AND SELECT ONLY ONE]

- HMO
- Doctor's office (non-HMO)
- Any clinic
- Emergency room
- Other outpatient

Specify:

- No regular source of medical care
- Don't know

24. Since your last visit in (MONTH), have you gone to ANY of the following sources for your outpatient medical care? (ASK EACH TIME) (This does not include dental health care, mental health care, home health care, clinical trials or other research studies, including MACS). [SHOW CARD WITH EXAMPLES OF EACH CATEGORY.]

SERVICE	a Have you used (EACH) since your last visit?	b How many times? (99 = 99 or more)	c And, have you used (EACH) in the last two weeks?
1) HMO	NO YES <input type="radio"/> GO TO NEXT ROW <input type="radio"/>	<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="radio"/> <input type="radio"/>
2) Doctor's office (non-HMO)	NO YES <input type="radio"/> GO TO NEXT ROW <input type="radio"/>	<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="radio"/> <input type="radio"/>
3) Any clinic	NO YES <input type="radio"/> GO TO NEXT ROW <input type="radio"/>	<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="radio"/> <input type="radio"/>
4) Emergency room	NO YES <input type="radio"/> GO TO NEXT ROW <input type="radio"/>	<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="radio"/> <input type="radio"/>
5) Other outpatient	NO YES <input type="radio"/> SKIP TO Q. 25 <input type="radio"/>	<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="radio"/> <input type="radio"/>

Specify:

25. How much did you or other personal sources (your lover, your family, or your friends) pay out-of-pocket, for your outpatient medical care since your last visit (including insurance deductibles, co-payments, services not covered by your insurance, and charges above the allowable limits of your insurance coverage)? [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN \$1]

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

OR Don't Know Refused

26. Since your last visit in (MONTH), have you used ANY of the following providers or services?

SERVICE	a Have you used (EACH) since your last visit in (MONTH)?	b How much did you or other personal sources (your lover, your family, or your friends) pay out-of-pocket, for this type of care since your last visit (including insurance deductibles, co-payments, services not covered by your insurance, and charges above the allowable limits of your insurance coverage)? [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN \$1]	OR <input type="radio"/> Don't Know <input type="radio"/> Refused
1) Dental health care provider (such as dentist or dental hygienist)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="text"/> 0 10M 20M 30M 40M 50M 60M 70M 80M 90M <input type="text"/> 0 1M 2M 3M 4M 5M 6M 7M 8M 9M <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <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	<input type="radio"/> Don't Know <input type="radio"/> Refused
2) Mental health care provider (psychiatrist, psychologist, social worker, other therapist/counselor)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="text"/> 0 10M 20M 30M 40M 50M 60M 70M 80M 90M <input type="text"/> 0 1M 2M 3M 4M 5M 6M 7M 8M 9M <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <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	<input type="radio"/> Don't Know <input type="radio"/> Refused
3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<input type="text"/> 0 10M 20M 30M 40M 50M 60M 70M 80M 90M <input type="text"/> 0 1M 2M 3M 4M 5M 6M 7M 8M 9M <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <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	<input type="radio"/> Don't Know <input type="radio"/> Refused
4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)	NO YES <input type="radio"/> <input type="radio"/> SKIP TO Q. 27	<input type="text"/> 0 10M 20M 30M 40M 50M 60M 70M 80M 90M <input type="text"/> 0 1M 2M 3M 4M 5M 6M 7M 8M 9M <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <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	<input type="radio"/> Don't Know <input type="radio"/> Refused

27. Please estimate the **TOTAL** out-of-pocket expenses that you or other personal sources (your lover, family or friends) paid for prescription medications since your last visit in (MONTH). [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN \$1]

0	10M	20M	30M	40M	50M	60M	70M	80M	90M
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

OR

Don't Know

Refused

28. **REFER TO HOSPITALIZATIONS:**
Was respondent hospitalized since his last visit?
 No → **SKIP TO Q. 29**
 Yes

[IF PARTICIPANT WAS HOSPITALIZED SINCE LAST VISIT, ASK:] You said you were hospitalized since your last visit. Please estimate the **TOTAL** out-of-pocket expenses that you or other personal sources (your lover, your family, or your friends) paid for the hospitalization(s) (including insurance deductibles, co-payments, services not covered by your insurance, and charges above the allowable limits of your insurance coverage).

0	10M	20M	30M	40M	50M	60M	70M	80M	90M
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

OR

Don't Know

Refused

29. A. Was there a time since your last visit in (MONTH) when you did not seek medical care that you thought you needed (not including dental care or prescription drugs)?

No → **SKIP TO Q. 29.D**
 Yes

B. If yes, why? [READ EACH REASON AND MARK ALL THAT APPLY.]

- Financial reasons
- Didn't want to reveal my HIV status
- Unable to find type of medical provider needed
- Fear of homophobia
- Other

Specify:

C. [IF "YES" TO MORE THAN ONE RESPONSE, ASK] Which of these was the main reason that you did not seek medical care? [MARK ONLY ONE RESPONSE]

- Financial reasons
- Didn't want to reveal my HIV status
- Unable to find type of medical provider needed
- Fear of homophobia
- Other

Specify:

D. Was there a time since your last visit when you were refused care from a doctor or other medical provider?

No Yes

30. A. Was there a time since your last visit in (MONTH) when you did not seek dental care that you thought you needed?

No → **SKIP TO Q. 30.D**
 Yes

B. If yes, why? [READ EACH REASON AND MARK ALL THAT APPLY.]

- Financial reasons
- Didn't want to reveal my HIV status
- Unable to find type of dental care provider needed
- Fear of homophobia
- Other

Specify:

C. [IF "YES" TO MORE THAN ONE RESPONSE, ASK] Which of these was the main reason that you did not seek dental care? [MARK ONLY ONE RESPONSE]

- Financial reasons
- Didn't want to reveal my HIV status
- Unable to find type of dental care provider needed
- Fear of homophobia
- Other

Specify:

D. Was there a time since your last visit when you were refused dental care?

No Yes

31. A. Was there a time since your last visit in (MONTH) when you did not obtain prescription medications that you thought you needed?

No → **SKIP TO Q. 32**
 Yes

B. If yes, why? [READ EACH REASON AND MARK ALL THAT APPLY.]

- Financial reasons
- Didn't want to reveal my HIV status
- Other

Specify:

C. [IF "YES" TO MORE THAN ONE RESPONSE, ASK] Which of these was the main reason that you did not obtain prescription drugs? [MARK ONLY ONE RESPONSE]

- Financial reasons
- Didn't want to reveal my HIV status
- Other

Specify:

32. At present, which of the following categories describes your annual individual gross income before taxes? [SHOW CARD TO PARTICIPANT OR READ ALOUD.]

- Less than \$10,000
- 10,000 - 19,999
- 20,000 - 29,999
- 30,000 - 39,999
- 40,000 - 49,999
- 50,000 or more
- Does not wish to answer

