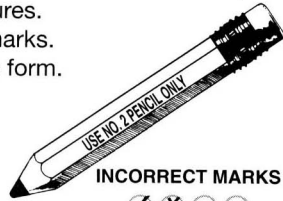


## MARKING INSTRUCTIONS

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



CORRECT MARK

INCORRECT MARKS

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

VISIT NO.	
2	1
0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

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

DATE		
MONTH	DAY	YEAR
Jan		9
Feb		
Mar	0	0
Apr	1	1
May	2	2
Jun	3	3
Jul	4	4
Aug	5	5
Sep	6	6
Oct	7	7
Nov	8	8
Dec	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 told you that you had it [since your last visit in (MONTH)]. 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 since your last visit?	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"/>	J F M A M J J A S O N D 83 84 85 86 87 88 89 90 91 92 93 94 Diagnosed before 1984	
B. Pneumocystis carinii pneumonia (PCP)	NO YES <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 93 94 Diagnosed before 1984	1 2 3 4 5 6 7 8 9
C. Other pneumonia, specify <input type="radio"/> Pneumococcal <input type="radio"/> Other bacterial <input type="radio"/> Viral <input type="radio"/> Other Specify: _____	NO YES <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 93 94 Diagnosed before 1984	1 2 3 4 5 6 7 8 9 If more than 1 time, in what month and year was the most recent episode? Specify: _____
D. Toxoplasmosis	NO YES <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 93 94 Diagnosed before 1984	
E. 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: _____	NO YES <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 93 94 Diagnosed before 1984	1 2 3 4 5 6 7 8 9
F. Mycobacterial infection (MAC, MAI or atypical TB)	NO YES <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 93 94 Diagnosed before 1984	

GET MEDICAL RELEASE



223270

Mark Reflex® by NCS EM-155095:321

Printed in U.S.A.



1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it <u>first</u> diagnosed since your last visit?																										
<b>G. Lymphoma, specify</b> <input type="radio"/> Primary brain lymphoma <input type="radio"/> Non-Hodgkin's <input type="radio"/> Other Specify: <input type="text"/>	NO <input type="radio"/> YES <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>93</td><td>94</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	93	94
	J	F	M	A	M	J	J	A	S	O	N	D																
	83	84	85	86	87	88	89	90	91	92	93	94																
<b>H. Cryptococcal meningitis</b>	NO <input type="radio"/> YES <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>93</td><td>94</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	93	94
	J	F	M	A	M	J	J	A	S	O	N	D																
	83	84	85	86	87	88	89	90	91	92	93	94																
<b>I. Candida in esophagus or lungs (not mouth)</b>	NO <input type="radio"/> YES <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>93</td><td>94</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	93	94
	J	F	M	A	M	J	J	A	S	O	N	D																
	83	84	85	86	87	88	89	90	91	92	93	94																
<b>J. Cryptosporidiosis</b>	NO <input type="radio"/> YES <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>93</td><td>94</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	93	94
	J	F	M	A	M	J	J	A	S	O	N	D																
	83	84	85	86	87	88	89	90	91	92	93	94																
<b>K. Wasting Syndrome</b>	NO <input type="radio"/> YES <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>93</td><td>94</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	93	94
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	83	84	85	86	87	88	89	90	91	92	93	94																
<b>L. Tuberculosis, specify</b> <input type="radio"/> Outside lungs <input type="radio"/> Inside lungs	NO <input type="radio"/> YES <input type="radio"/> GO TO Q 2	<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>93</td><td>94</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	93	94
	J	F	M	A	M	J	J	A	S	O	N	D																
	83	84	85	86	87	88	89	90	91	92	93	94																

2.A. [Since your last visit in (MONTH)] Has a doctor or other medical practitioner told you that you had less than 200 CD4<sup>+</sup> T-lymphocytes/ $\mu$ L or that they were less than 14%?

CD4 LYMPHOCYTES = CD4<sup>+</sup> T-CELLS = HELPER T-CELLS

☐ No ☐ Yes  
 SKIP TO Q 3

In what month and year were you first told since your last visit?

	J	F	M	A	M	J	J	A	S	O	N	D
	83	84	85	86	87	88	89	90	91	92	93	94

Diagnosed before 1984

B. Were these results based on laboratory data outside this study?

☐ No  
☐ Yes  
☐ Don't know

GET MEDICAL RELEASE



3. [Since your last visit in (MONTH)] In addition to these diagnoses, has a doctor or medical practitioner told you that you have had any other AIDS conditions?

☐ No  
☐ Yes

SKIP TO Q 4

a	b																										
IF "YES": What was the diagnosis?	In what month and year was it first diagnosed since your last visit?																										
1) Specify: <input type="text"/>	<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>93</td><td>94</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	93	94
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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	92	93	94															

4. Has a doctor or medical practitioner ever told you that you had some form of cancer (excluding Kaposi's sarcoma, primary brain lymphoma and non-Hodgkin's lymphoma)?

☐ No  
☐ Yes

IF "NO", GO TO Q 5

a	b																																																																		
IF YES: What kind of cancer did they say it was?	In what month and year was it first diagnosed?																																																																		
1) Site <input type="text"/> Type <input type="text"/> <table border="1"> <tr> <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>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	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><td>93</td><td>94</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	93	94
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	83	84	85	86	87	88	89	90	91	92	93	94																																																							

GET MEDICAL RELEASE



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

- ☐ No  
☐ Yes

**SKIP TO Q 6**

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									
		0	1	2	3	4	5	6	7	8	9			
YEAR		84	85	86	87	88	89	90	91	92	93	94		

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 QUESTIONS 1-3 AS APPROPRIATE**


**IF ONLY ONE HOSPITALIZATION  
(SEE RESPONSE TO 5.A), SKIP TO QUESTION 6**

**5.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			
YEAR		84	85	86	87	88	89	90	91	92	93	94		

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 QUESTIONS 1-3 AS APPROPRIATE**


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

- ☐ No  
☐ Yes

**SKIP TO Q 6**

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

**6. Have you ever been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?**

- ☐ No  
☐ Yes  
☐ Don't know

**GET MEDICAL RELEASE**

**IF YES: which month and year was the most recent time?**

	J	F	M	A	M	J	J	A	S	O	N	D
	83	84	85	86	87	88	89	90	91	92	93	94

Before 1984

**7. Have any members of your immediate blood-related family ever been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?**

- ☐ No  
☐ Yes  
☐ Don't know



8.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  
☐ Yes

REVIEW RESPONSE TO Q 4, IF DIAGNOSED WITH CANCER USE PROMPT  
AND REASK QUESTION, SKIP TO Q 9

B. How many times have you had a biopsy [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	b	c
Site of biopsy	What did they say the diagnosis or result of the biopsy was?	Name of the doctor who performed the biopsy and where the biopsy was performed?
1) Specify: <input type="text"/> <input type="text"/> <input type="text"/> <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	Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Name of doctor <input type="text"/> Name of hospital/center/clinic <input type="text"/> City <input type="text"/> State <input type="text"/>
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3) Specify: <input type="text"/> <input type="text"/> <input type="text"/> <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	Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Name of doctor <input type="text"/> Name of hospital/center/clinic <input type="text"/> City <input type="text"/> State <input type="text"/>

9. Have you ever received an injection of pneumococcal vaccine/Pneumovax?

NO YES

☐ ☐

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

☐ ☐

IF YES: Was it positive?

☐ ☐

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

A. Shingles (or herpes zoster)

☐ ☐

IF YES: Which month and year (since your last visit) did this episode of shingles (zoster) begin?

J F M A M J J A S O N D  
 83 84 85 86 87 88 89 90 91 92 93 94

Diagnosed before 1984

B. Sinusitis

☐ ☐

C. Bronchitis

☐ ☐

D. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis].

NO YES

☐ ☐

IF YES: Was it: (Read and answer each)

Hepatitis A or infectious hepatitis

☐ ☐

Hepatitis B or serum hepatitis

☐ ☐

Non-A/Non-B hepatitis or hepatitis C

☐ ☐

Other

Specify:

Didn't say which kind it was

☐ ☐



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

NO YES

☐ ☐

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

☐ ☐

G. [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?

☐ ☐

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

☐ ☐

**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

H. 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?

☐ ☐

**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

12.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 13**

B. Did the first attack of herpes you ever had occur since your visit in (MONTH)?

☐ ☐

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?

☐ ☐

13. 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
A) Syphilis	<input type="radio"/>	<input type="radio"/>
B) Any form of gonorrhea	<input type="radio"/>	<input type="radio"/>
<b>IF "NO" TO (B), SKIP TO (F)</b>		
C) Urethral gonorrhea (clap or drip of the urinary passage)	<input type="radio"/>	<input type="radio"/>
D) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>
E) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>
F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that's not caused by gonorrhea)	<input type="radio"/>	<input type="radio"/>
G) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>
H) Molluscum contagiosum	<input type="radio"/>	<input type="radio"/>
I) Any of the following: shigellosis, salmonellosis, amoebic dysentery, giardiasis or any other parasitic disease, including worms	<input type="radio"/>	<input type="radio"/>

Specify:



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

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	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 ROW		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)].	
	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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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 84 85 86 87 88 89 90 91 92 93 94	
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="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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
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"/>	<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 84 85 86 87 88 89 90 91 92 93 94	
16) HIV-related symptoms Specify:	<input type="radio"/>	<input type="radio"/>								



15. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes?

- ☐ No → **SKIP TO Q 16**  
☐ Yes

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

- ☐ No → **SKIP TO Q 16**  
☐ Yes  
☐ Occasionally (less than one cigarette per day)

**SKIP TO Q 16**

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

16. 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.)

- |  |   |
|--|---|
| <input type="radio"/> At least once a day  | <input type="radio"/> About once a month  |
| <input type="radio"/> Nearly every day     | <input type="radio"/> 6 - 11 times a year |
| <input type="radio"/> 3 to 4 times a week  | <input type="radio"/> 1 - 5 times a year  |
| <input type="radio"/> Once or twice a week | <input type="radio"/> Not at all          |
| <input type="radio"/> 2 or 3 times a month |   |

**SKIP TO Q 17**

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.

- |                                     |  |
|-------------------------------------|--|
| <input type="radio"/> 1 or 2 drinks | <input type="radio"/> 5 or 6 drinks    |
| <input type="radio"/> 3 or 4 drinks | <input type="radio"/> 7 or more drinks |

**IF PARTICIPANT HAS HAD AN AIDS DIAGNOSIS,  
SKIP TO Q 18**

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

- ☐ No  
☐ Yes

18. Since your last visit, have you taken any HIV-related medications or treatments? (That is, medications or treatments to suppress or prevent HIV infection, treat or prevent opportunistic or malignant diseases, symptoms or problems of HIV infection or medications which boost the immune system.)

- ☐ No → **SKIP TO Q 19**  
☐ 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 18.B**  
☐ Yes

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

**FILL IN THE BUBBLE NEXT TO THE DRUG(S).**

- ☐ Acyclovir (ACV, Zovirax)  
☐ AL-721  
☐ Alpha Interferon  
☐ Ampligen  
☐ AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)  
☐ AZT/ddC  
☐ AZT/ddI  
☐ AZT/ddI/ddC  
☐ Beta Interferon  
☐ d4T  
☐ ddC (dideoxycytidine, HIVID, Zalcitabine)  
☐ ddI (dideoxyinosine, Didanosine, Videx)  
☐ ddI/ddC  
☐ Dextran-Sulfate  
☐ Foscarnet (Phosphonoformate, PFA)  
☐ Peptide T  
☐ Recombinant CD4  
☐ Ribavirin  
☐ Other anti-viral

Specify:

**COMPLETE FORM I FOR EACH DRUG  
MARKED ABOVE IN Q 18.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  
☐ Yes

→ SKIP TO Q 18.C

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

1.	2.	3.
4.	5.	6.
7.	8.	9.
10.	11.	12.

COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q 18.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  
☐ Yes

→ SKIP TO Q 19

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

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



19. 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? FOR ITEMS 10a-c ALSO ASK What did you take this drug for?
IF "NO" TO a GO TO NEXT ITEM	NO YES	
1) Steroids that you took orally or were injected	<input type="radio"/> NO <input type="radio"/> YES	
2) Some other kind of hormone such as anabolic steroids, insulin or thyroxine	<input type="radio"/> NO <input type="radio"/> YES	
3) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/> NO <input type="radio"/> YES	
4) Medication taken by mouth for fungal infection	<input type="radio"/> NO <input type="radio"/> YES	
5) Medication taken by mouth for worms or parasites	<input type="radio"/> NO <input type="radio"/> YES	
6) Tranquilizers or sleeping pills	<input type="radio"/> NO <input type="radio"/> YES	
7) Antidepressants or mood elevators	<input type="radio"/> NO <input type="radio"/> YES	
8) Lithium	<input type="radio"/> NO <input type="radio"/> YES	
9) Acyclovir (Zovirax) for herpes	<input type="radio"/> NO <input type="radio"/> YES	

<b>10) a. Other (SPECIFY in column b)</b> _____ <div> <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 </div>	<input type="radio"/> NO <input type="radio"/> YES <b>SKIP TO Q 20</b>	Name: _____ Use for: _____
<b>b. Other (SPECIFY in column b)</b> _____ <div> <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 </div>	<input type="radio"/> NO <input type="radio"/> YES <b>SKIP TO Q 20</b>	Name: _____ Use for: _____
<b>c. Other (SPECIFY in column b)</b> _____ <div> <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 </div>	<input type="radio"/> NO <input type="radio"/> YES <b>SKIP TO Q 20</b>	Name: _____ Use for: _____

20. Since your visit in (MONTH), have you used a therapeutic vaccine against HIV-1?

☐ No  
☐ Yes

21. Since your visit in (MONTH), were you enrolled in a HIV-related vaccine trial?

☐ No  
☐ Yes



22. 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 26**  
☐ 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 23A and B, DO NOT ask Q 23C].
- ☐ **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 23C asking for women only and then skip to Q 26.
- ☐ **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.

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

MEN		WOMEN																																																																																											
<b>A. With how many different men (if any) have you had sexual intercourse [since your last visit in (MONTH)]?</b> <b>READ DEFINITION OF INTERCOURSE.</b>	<b>B. With how many other men have you had sexual activity that did <u>not</u> include intercourse?</b>	<b>C. With how many different women (if any), have you had sexual intercourse [since your visit in (MONTH)]?</b>																																																																																											
<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>	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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 INTERCOURSE WITH ONLY ONE (1) PARTNER, ASK QUESTION 24, ELSE SKIP TO QUESTION 25.**

24. 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 25**
- 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 25**

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



25. 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 masturbated your partner until your partner ejaculated/came.	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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2) You put your penis in his mouth. * IF NONE, SKIP TO ITEM (5). *	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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3) IF MULTIPLE PARTNERS: With how many of those ____ partners had you used a condom <u>every</u> time even if it broke, tore or slipped? * IF ONE PARTNER: * Did you use a condom <u>every</u> time even if 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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4) You ejaculated/came into his mouth. *	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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5) You used your tongue to touch or lick his anus ("rimming").	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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6) You put your penis into your partner's rectum (anal insertive intercourse). * IF NONE, SKIP TO ITEM (12). *	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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7) IF MULTIPLE PARTNERS: With how many of those ____ partners had you used a condom <u>every</u> time even if it broke, tore or slipped? * IF ONE PARTNER: * Did you use a condom <u>every</u> time even if it broke, tore or slipped? *	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 11	<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 <div>IF ALL PARTNERS, SKIP TO ITEM (11)</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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8) IF MULTIPLE PARTNERS: With how many of those ____ partners had you used a condom <u>only some of the times</u> ? * IF ONE PARTNER: * Did you sometimes use a condom? *	NO YES <input type="radio"/> <input type="radio"/> SKIP TO ITEM 10	<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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9) With how many of those ____ partners was a condom <u>never</u> used? *		<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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10) IF MULTIPLE PARTNERS: 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></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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## 25. 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 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?)																																	
<p>IF NO CONDOM USE, SKIP TO ITEM 12</p> <p>IF MULTIPLE PARTNERS:</p> <p>11) 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?</p> <p>IF ONE PARTNER:</p> <p>* Did you use a condom when it broke, tore or slipped?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>ASK ITEMS (12, 13, and 14) OF ALL NEW RECRUITS, LOCAL OPTION TO ASK OF OTHERS</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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	0	1	2	3	4	5	6	7	8	9																									
<p>12) You put your whole hand or fist into his rectum ("fisting").</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>13) You inserted your finger or fingers (but not whole hand) into your partner's rectum.</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>14) You used a douche or enema before having sex.</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>15) He put his penis in your mouth. * IF NONE, SKIP TO ITEM (18)</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>IF MULTIPLE PARTNERS:</p> <p>16) How many of those ___ partners used a condom every time even if it broke, tore or slipped?</p> <p>IF ONE PARTNER:</p> <p>* Did he use a condom every time even if it broke, tore or slipped?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>17) He ejaculated/came into your mouth. *</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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<p>18) He used his tongue to touch or lick your anus ("rimming").</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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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>19) He put his penis in your rectum (anal receptive intercourse). * IF NONE, SKIP TO ITEM (25).</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<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> <p>partners</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
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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>20) How many of those ___ partners used a condom every time even if it broke, tore or slipped?</p> <p>IF ONE PARTNER:</p> <p>* Did he use a condom every time even if it broke, tore or slipped?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO ITEM 24</p>	<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> <p>partners</p> <p>IF ALL PARTNERS, SKIP TO ITEM (24)</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
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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>21) How many of those ___ partners used a condom only some of the times?</p> <p>IF ONE PARTNER:</p> <p>* Did he sometimes use a condom?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO ITEM 23</p>	<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> <p>partners</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
	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																									



## 25. 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 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?)																														
22) How many of those ___ partners <u>never</u> used a condom? *		<table border="1"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> partners	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9
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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: 23) 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>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 NO CONDOM USE, SKIP TO ITEM 25 IF MULTIPLE PARTNERS: 24) 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>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																							
ASK ITEMS 25 and 26 OF ALL NEW RECRUITS, LOCAL OPTION TO ASK OF OTHERS																																
25) He put his whole hand or fist into your rectum ("fisting").	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
0	100	200	300	400	500	600	700	800	900																							
0	10	20	30	40	50	60	70	80	90																							
0	1	2	3	4	5	6	7	8	9																							
26) 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>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																							

26. 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 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 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"/>	
"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"/>	NO YES <input type="radio"/> <input type="radio"/>
Other kinds of drugs	NO YES <input type="radio"/> <input type="radio"/> GO TO Q 27	<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.

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

NO YES

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

Specify:

0 1 2 3 4 5 6 7 8 9

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

C. [IF YES TO PRIVATE OR OTHER INSURANCE  
(Q 27.A. 1), 2), 3), OR 8)), ASK Q 27.C,  
OTHERWISE GO TO Q 27.D.]

NO YES

- 1) Does your employer pay all or  
part of the cost of your health  
insurance premiums? ☐ NO ☐ YES
- 2) Do you have coverage by  
COBRA benefits, that is, have  
you stopped working but  
remained part of your employer  
group health insurance plan? ☐ NO ☐ YES
- 3) IF YES: Does the state pay any  
of the cost of the COBRA health  
insurance premium? ☐ NO ☐ YES

D. Did you lose private health  
insurance coverage at any time  
since your last visit, even  
temporarily? ☐ NO ☐ YES

E. 1) Have you applied for private  
health insurance at any time  
since your last visit? ☐ NO ☐ YES

2) IF YES: Have you been refused  
health insurance coverage at  
any time since your last visit? ☐ NO ☐ YES

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

- ☐ No  
☐ Yes

29. 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

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]

\$

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



30. Since your visit in (MONTH), have you gone to ANY of the following sources for your outpatient medical care? (ASK FOR EACH ITEM) (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 31 <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:   0 1 2 3 4 5 6 7 8 9

31. 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]

\$  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



32. 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 many times? (99 = 99 or more)	c 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]	d And have you used (EACH) in the last two weeks?
1) Dental health care provider (such as dentist or dental hygienist)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div>	<div> <div>\$</div> <div>0 10M 20M 30M 40M 50M 60M 70M 80M 90M</div> </div> <div> <div></div> <div>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</div> </div> <div> <div></div> <div>0 100 200 300 400 500 600 700 800 900</div> </div> <div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div> <div>OR <input type="radio"/> Don't know <input type="radio"/> Refused</div>	<input type="radio"/> NO  <input type="radio"/> YES
2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/counselor)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div>	<div> <div>\$</div> <div>0 10M 20M 30M 40M 50M 60M 70M 80M 90M</div> </div> <div> <div></div> <div>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</div> </div> <div> <div></div> <div>0 100 200 300 400 500 600 700 800 900</div> </div> <div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div> <div>OR <input type="radio"/> Don't know <input type="radio"/> Refused</div>	<input type="radio"/> NO  <input type="radio"/> YES
3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div>	<div> <div>\$</div> <div>0 10M 20M 30M 40M 50M 60M 70M 80M 90M</div> </div> <div> <div></div> <div>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</div> </div> <div> <div></div> <div>0 100 200 300 400 500 600 700 800 900</div> </div> <div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div> <div>OR <input type="radio"/> Don't know <input type="radio"/> Refused</div>	<input type="radio"/> NO  <input type="radio"/> YES
4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)	<input type="radio"/> NO GO TO Q 33  <input type="radio"/> YES	<div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div>	<div> <div>\$</div> <div>0 10M 20M 30M 40M 50M 60M 70M 80M 90M</div> </div> <div> <div></div> <div>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</div> </div> <div> <div></div> <div>0 100 200 300 400 500 600 700 800 900</div> </div> <div> <div></div> <div>0 10 20 30 40 50 60 70 80 90</div> </div> <div> <div></div> <div>0 1 2 3 4 5 6 7 8 9</div> </div> <div>OR <input type="radio"/> Don't know <input type="radio"/> Refused</div>	<input type="radio"/> NO  <input type="radio"/> YES



33. 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

34. **REFER TO HOSPITALIZATIONS:**  
 Was respondent hospitalized since his last visit?

- ☐ No  
☐ Yes

SKIP TO Q 35

[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

- 35.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  
☐ Yes

SKIP TO Q 35.D

- 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:

- 35.C. [IF "YES" TO MORE THAN ONE RESPONSE IN Q 35.B., 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

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

- ☐ No  
☐ Yes

SKIP TO Q 36.D

- 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 IN Q 36.B., 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



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

- ☐ No  
☐ Yes

SKIP TO Q 38

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 IN Q 37.B, 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:

38. 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

39. Are you experiencing major financial difficulty meeting your basic expenses?

- ☐ No  
☐ Yes

SKIP TO Q 40

IF YES: Is the difficulty less, the same or greater than at your last visit in (MONTH)

- ☐ Less  
☐ Same  
☐ Greater

40. Since your last visit, has your employment status changed for any reason related to HIV disease?

- ☐ No  
☐ Yes

SKIP TO Q 41

IF YES: ASK: What were the reasons?  
(READ EACH ITEM)

NO YES

- 1) Became too sick to work  
2) HIV status became known to employer  
3) HIV status became known to coworkers  
4) Early retirement  
5) Changed job as a personal decision  
6) To receive better health insurance benefits  
7) To receive better disability benefits  
8) Other

Specify:

0 1 2 3 4 5 6 7 8 9

41.A. Is there anything more that I haven't asked that you think we should know?

- ☐ No, nothing more  
☐ Yes

THANK PARTICIPANT  
AND SKIP TO Q 42

B. Tell me about it.  
RECORD FULLY IN R's OWN WORDS.



☐ No

☐ Yes

☐ No

☐ Yes

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Date interview completed

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Interviewer's signature

INTERVIEWER'S NUMBER										
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