FOLLOW-UP VISIT SECTION 4

MARKING INSTRUCTIONS

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

ID NUMBER	VISIT NO.	TIME BEGAN HR	TIME BEGAN MIN	DATE MONTH	DATE DAY	DATE YEAR
	28			Jan		9
				Feb		
				Mar	00	
				Apr	11	
				May	22	
				June	33	
				July	4	
				Aug	5	97
				Sept	6	98
				Oct	7	
				Nov	8	
				Dec	9	

1. Let's start with a list of medical conditions. Since your last visit [in (MONTH, YEAR)], were you diagnosed with any of the following? How about (EACH)?

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year (since your last visit), was it [first] diagnosed?	c How many times were you diagnosed with this since your last visit? FOR 9 OR MORE TIMES CODE "9"
A. Kaposi's sarcoma	NO ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	
B. Pneumocystis carinii pneumonia (PCP)	NO ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	1 2 3 4 5 6 7 8 9
C. Other pneumonia, specify ○ Pneumococcal ○ Other bacterial ○ Viral ○ Other Specify:	NO ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	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 ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	
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.)** ○ Eyes ○ Lung ○ Colon ○ Other (not blood) Specify:	NO ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	1 2 3 4 5 6 7 8 9
F. Mycobacterial infection (MAC, MAI or atypical TB)	NO ○ GO TO NEXT ROW / YES ○	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98	

GET MEDICAL RELEASE

PLEASE DO NOT WRITE IN THIS AREA

244710

1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it first diagnosed since your last visit?
G. Lymphoma, specify ○ Primary brain lymphoma ○ Non-Hodgkin's ○ Other Specify	NO ○ YES ○ GO TO NEXT ROW	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
H. Cryptococcal meningitis	NO ○ YES ○ GO TO NEXT ROW	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
I. Candida in esophagus or lungs (not mouth)	NO ○ YES ○ GO TO NEXT ROW	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
J. Cryptosporidiosis	NO ○ YES ○ GO TO NEXT ROW	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
K. Wasting Syndrome	NO ○ YES ○ GO TO NEXT ROW	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
L. Tuberculosis, specify ○ Outside lungs ○ Inside lungs	NO ○ YES ○ GO TO Q 2	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98

2.A. [Since your last visit in (MONTH)] Have you had a $CD4^+$ T-cell count less than 200 (per µl) or a percentage less than 14%?

CD4 LYMPHOCYTES = $CD4^+$ T-CELLS = HELPER T-CELLS

○ No → SKIP TO Q 3

○ Yes

In what month and year were you first told?

J F M A M J J A S O N D
84 85 86 87 88 89 90 91 92 93 94 95 96 97 98

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 → SKIP TO Q 4
○ Yes

a IF "YES": What was the diagnosis?	b In what month and year was it first diagnosed since your last visit?
1) Specify:	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98
2) Specify:	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98
3) Specify:	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98

4. [Since your last visit in (MONTH)] Has a doctor or medical practitioner told you that you had some form of cancer (excluding Kaposi's sarcoma, primary brain lymphoma and non-Hodgkin's lymphoma)?

○ No → IF "NO," GO TO Q 5
○ Yes

a IF YES: What kind of cancer did they say it was?		b In what month and year was it first diagnosed since your last visit?
1) Site / 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	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98
2) Site / 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	J F M A M J J A S O N D / 87 88 89 90 91 92 93 94 95 96 97 98

GET MEDICAL RELEASE

c What was the name and address of the physician who diagnosed the cancer?
1) Name of hospital/clinic or doctor Address City State
2) Name of hospital/clinic or doctor Address City State

5.A. [Since your last visit in (MONTH)] Have you been hospitalized overnight?

○ No → **SKIP TO Q 6**

○ 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
	0 1 2 3 4 5 6 7 8 9
YEAR	87 88 89 90 91 92 93 94 95 96 97 98

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 and the name/address of the hospital?
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	87 88 89 90 91 92 93 94 95 96 97 98

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 and the name/address of the hospital?
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 → **SKIP TO Q 6**

○ Yes

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

6. Since your last visit, have you been hospitalized, prescribed medication, or consulted a mental health professional for treatment of depression?

○ No

○ Yes → **GET MEDICAL RELEASE**

○ Don't know

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

	J F M A M J J A S O N D
	84 85 86 87 88 89 90 91 92 93 94 95 96 97 98

Before 1985

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 → REVIEW RESPONSE TO Q 4, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 9
○ Yes

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 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, where the biopsy was performed and the date of the biopsy?
1) Specify:	Specify:	Name of doctor Name of hospital/center/clinic City State DATE
2) Specify:	Specify:	Name of doctor Name of hospital/center/clinic City State DATE
3) Specify:	Specify:	Name of doctor Name of hospital/center/clinic City State DATE

GET MEDICAL RELEASE

	NO	YES
9. Have you ever received an injection of pneumococcal vaccine/Pneumovax?	○	○
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 / 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98		
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	○	○

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

	NO	YES
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

IF MORE THAN 3 DIAGNOSES, MARK HERE AND RECORD OTHER CONDITIONS IN BOX. ○

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

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

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	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
2) A new skin condition or infection that lasted for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
3) Diarrhea for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
4) Persistent or recurring fever higher than 100° for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
5) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
6) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
7) Drenching sweats at night on at least 3 occasions	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
8) Thrush, candida or white patches in your mouth or throat	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
9) An unusual bruise or bump or skin discoloration that lasted at least two weeks	○	○			○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
10) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	○	○			○	○	○	○	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98
11) Other HIV-related symptoms Specify:	○	○							

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 <u>often</u> 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 18

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

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).

- ○ 3-TC (Epivir, Lamivudine)
- ○ AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)
- ○ d4T (Zerit, Stavudine)
- ○ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ○ ddI (dideoxyinosine, Didanosine, Videx)
- ○ Delavirdine
- ○ Indinavir (Crixivan)
- ○ Nelfinavir (Viracept)
- ○ Nevirapine (Viramune)
- ○ Ritonavir (Norvir)
- ○ Saquinavir (Invirase)
- ○ Other anti-viral

Specify

(3) [Since your last visit (MONTH)], was there a time when you missed at least 2 consecutive days of prescribed antiretroviral therapy?

- ○ No
- ○ Yes

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 → **SKIP TO Q 18.C**
- ○ Yes

(2) Please name those drugs that you have taken. (FILL IN THE BUBBLE NEXT TO THE DRUG(S). FOR DRUGS NOT ON THE LIST, RECORD THE NAME UNDER "OTHER" AS STATED BY THE PARTICIPANT.)

- ○ Atovaquone (BW566C80, Mepron)
- ○ Azithromycin (Zithromax)
- ○ Bactrim (Septra)
- ○ Ciprofloxacin (CIPRO)
- ○ Clarithromycin (Biaxin)
- ○ Clofazimine (Lamprene)
- ○ Co-enzyme Q
- ○ Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
- ○ Dapsone
- ○ DNCB
- ○ Ethambutol
- ○ Erythropoietin (Epogen)
- ○ Flagyl (metronidazole)
- ○ Fluconazole (Diflucan)
- ○ Ganciclovir (DHPG)
- ○ Hypericin (HY)
- ○ Interleukin-2 (IL-2)
- ○ Itraconazole
- ○ Ketoconazole (Nizoral)
- ○ Megace
- ○ Mycelex (clotrimazole)
- ○ NAC (N-acetyl-cysteine)
- ○ Nystatin (Mycostatin)
- ○ Pentamidine (aerosolized)
- ○ Pentamidine (IV)
- ○ Rifabutin (Ansamycin, Mycobutin)
- ○ Rifampin (Rifadin)
- ○ Tagamet (cimetidine)
- ○ Trental (pentoxifylline)
- ○ Vaccine trial (generic)
- ○ Other →

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

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 → **SKIP TO Q 19**
- ○ Yes

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

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

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) IF "NO" TO a GO TO NEXT ITEM	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?
1) Steroids that you took orally or were injected	NO ○ YES ○	
2) Some other kind of hormone such as anabolic steroids, insulin or thyroxine	○ ○	
3) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	○ ○	
4) Medication taken by mouth for fungal infection	○ ○	
5) Medication taken by mouth for worms or parasites	○ ○	
6) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? ○ No ○ Yes	○ ○	
7) Antidepressants or mood elevators	○ ○	
8) Lithium	○ ○	
9) Acyclovir (Zovirax) for herpes	○ ○	
10) a. Other (SPECIFY in column b) →	○ ○ SKIP TO Q 20	Name: Use for:
b. Other (SPECIFY in column b) →	○ ○ SKIP TO Q 20	Name: Use for:
c. Other (SPECIFY in column b) →	○ ○ SKIP TO Q 20	Name: Use for:
d. Other (SPECIFY in column b) →	○ ○ SKIP TO Q 20	Name: Use for:
e. Other (SPECIFY in column b) →	○ ○ SKIP TO Q 20	Name: Use for:

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

○ No
○ Yes

Q 21 HAS BEEN DELETED. SKIP TO Q 22.

*** IF PARTICIPANT HAS HAD AN AIDS DIAGNOSIS, SKIP TO QUESTION 27 ON PAGE 15**
[LOCAL OPTION-CENTERS MAY ASK QUESTIONS (22–26)]

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

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

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	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

Q 24 HAS BEEN DELETED. SKIP TO Q 25.

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.

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 used your tongue to touch or lick his anus ("rimming").	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9

IF NO INTERCOURSE, SKIP TO Q 26.

2) You put your penis in his mouth. IF NONE, SKIP TO ITEM (5).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 3) With how many of those ___ partners had you used a condom every time for oral sex even if it broke, tore or slipped? IF ONE PARTNER: Did you use a condom every time for oral sex even if it broke, tore or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
4) You ejaculated/came into his mouth.	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9

5) You put your penis into your partner's rectum (anal insertive intercourse). IF NONE, SKIP TO ITEM (8).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
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 ○ SKIP TO ITEM 8	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9 IF ALL PARTNERS, SKIP TO ITEM (8)
IF MULTIPLE PARTNERS: 7) 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 ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 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.

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?)
8) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 9) How many of those ___ partners used a condom every time for oral sex even if it broke, tore or slipped? **IF ONE PARTNER:** Did he use a condom every time for oral sex even if it broke, tore or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
10) He put his penis in your rectum (anal receptive intercourse). IF NONE, SKIP TO Q 26).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 11) How many of those ___ partners used a condom every time even if it broke, tore or slipped? **IF ONE PARTNER:** Did he use a condom every time even if it broke, tore or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 partners 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 ○ GO TO NEXT ROW ○ YES	○	○	○	○	
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○	
Crack or cocaine that you smoke	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○	
Other forms of cocaine	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○	NO ○ YES ○
Crystal, Methamphetamine	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○	NO ○ YES ○
Ecstacy	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○	
Other kinds of drugs	NO ○ GO TO Q 27 ○ YES	○	○	○	○	NO ○ YES ○

Specify: ____ ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

Specify: ____ ○ 0 ○ 1 ○ 2 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9

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	○	○
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)	○	○
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)	○	○
4) Medicaid, Medi-Cal, or Medical Assistance	○	○
5) Medicare (for people over 65 or permanently disabled)	○	○
6) Health care benefits for The Armed Forces or Veteran's Administration	○	○
7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans	○	○
8) Other	○	○

Specify:

0 1 2 3 4 5 6 7 8 9

IF NO TO (1)–(8), SKIP TO E, THEN SKIP TO Q 31

Q 27B HAS BEEN DELETED.

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

	NO	YES
C. Did your employer pay all or part of the cost of your health insurance premiums?	○	○
D. Did you lose <u>private</u> 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) <u>IF YES</u>: Have you been refused health insurance coverage at any time since your last visit?	○	○

IF NO MEDICAL COVERAGE SINCE LAST VISIT, I.E., NO TO Q 27.A (1)–(8), THEN SKIP TO Q 31.

28. A. Since your last visit, have you changed or lost your medical coverage? NO ○ YES ○ → SKIP TO Q 29

B. If YES, was that change your choice? ○ ○

C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION]

	NO	YES
1) Lost or quit job	○	○
2) Changed job (employer or employment status)	○	○
3) Employer changed or dropped coverage	○	○
4) Pre-existing medical condition limited choices	○	○
5) To be able to choose doctors or providers	○	○
6) More or better coverage of needed or desired services	○	○
7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed	○	○
8) Financial reasons (cost of premiums, co-payments or deductibles)	○	○
9) Eligible for Medicare	○	○

D. [IF "YES" TO MORE THAN ONE RESPONSE IN Q 28.C, ASK] Which one was the PRIMARY reason? [READ ALL CHOICES AND SELECT ONLY ONE]

- ○ Lost or quit job
- ○ Changed job (employer or employment status)
- ○ Employer changed or dropped coverage
- ○ Pre-existing medical condition limited choices
- ○ To be able to choose doctors or providers
- ○ More or better coverage of needed or desired services
- ○ Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed
- ○ Financial reasons (cost of premiums, co-payments or deductibles)
- ○ Eligible for Medicare

28.E. Are you currently insured?

- ○ No → SKIP TO Q 31
- ○ Yes

29.A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)

	NO	YES
1) Employer offers only one plan	○	○
2) Only eligible for current coverage due to medical condition	○	○
3) To be able to choose doctors or providers	○	○
4) To have more or better coverage of needed or desired services	○	○
5) Eligible for Medicaid, Medi-Cal, or Medical Assistance	○	○
6) Financial reasons (cost of premiums, co-payments or deductibles)	○	○
7) Eligible for Medicare	○	○

B. [IF "YES" TO MORE THAN ONE RESPONSE IN Q29.A, ASK] What was the PRIMARY reason for choosing your current medical coverage? [READ ALL CHOICES AND SELECT ONE]

- ○ Employer offers only one plan
- ○ Only eligible for current coverage due to medical condition
- ○ To be able to choose doctors or providers
- ○ To have more or better coverage of needed or desired services
- ○ Eligible for Medicaid, Medi-Cal, or Medical Assistance
- ○ Financial reasons (cost of premiums, co-payments or deductibles)
- ○ Eligible for Medicare

30. All things considered, how satisfied are you with your current health insurance plan? [SHOW CARD TO PARTICIPANT OR READ ALOUD]

- ○ 1) Completely satisfied, couldn't be better
- ○ 2) Very satisfied
- ○ 3) Somewhat satisfied
- ○ 4) Neither satisfied nor dissatisfied
- ○ 5) Somewhat dissatisfied
- ○ 6) Very dissatisfied
- ○ 7) Completely dissatisfied, couldn't be worse

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

- ○ No
- ○ Yes

32. 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

33. 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)
1) HMO	NO ○ GO TO NEXT ROW / YES ○	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
2) Doctor's office (non-HMO)	NO ○ GO TO NEXT ROW / YES ○	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
3) Any clinic	NO ○ GO TO NEXT ROW / YES ○	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
4) Emergency room	NO ○ GO TO NEXT ROW / YES ○	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
5) Other outpatient	NO ○ GO TO Q 34 / YES ○	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9

Specify:

0 1 2 3 4 5 6 7 8 9

Q 34 HAS BEEN DELETED. SKIP TO Q 35.

35. 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)
1) Dental health care provider (such as dentist or dental hygienist)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
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 GO TO Q 36 ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

36. 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

Q 37 HAS BEEN DELETED. SKIP TO Q 38.

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

- No → SKIP TO Q 39
- Yes

B. IF YES: Was there a time that you did not seek [obtain] (READ EACH) you thought you needed?

1) Medical care
- No → GO TO (2)
- Yes → Why did you not seek medical care?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons
- Other non-financial reasons

Specify:

2) Dental care
- No → GO TO (3)
- Yes → Why did you not seek dental care?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons
- Other non-financial reasons

Specify:

3) Prescription Medications
- No → GO TO Q 39
- Yes → Why did you not obtain prescription medications?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons
- Other non-financial reasons

Specify:

39. Was there a time since your last visit when you were refused care from a doctor or other medical provider?
- No
- Yes

40. Was there a time since your last visit when you were refused dental care?
- No
- Yes

41. 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

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

- ◯ No → **SKIP TO Q 43**
- ◯ Yes

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

- ◯ Less
- ◯ Same
- ◯ Greater

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

- ◯ No → **SKIP TO Q 44**
- ◯ Yes

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

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

- ◯ No, nothing more → **THANK PARTICIPANT AND SKIP TO Q 45**
- ◯ Yes

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

45. Telephone interview?

- ○ No
- ○ Yes

46. Home visit?

- ○ No
- ○ Yes

47. PWA interview?

- ○ No
- ○ Yes

48.

199

Date interview completed

TIME ENDED

HR		MIN		
0	0	0	0	
10	1	10	1	AM ○
	2	20	2	
	3	30	3	
	4	40	4	PM
	5	50	5	○
	6		6	
	7		7	
	8		8	
	9		9	

49.

Interviewer's signature

INTERVIEWER'S NUMBER

	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