

## 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	VISIT NO.	TIME BEGAN		DATE		
		HR	MIN	MONTH	DAY	YEAR
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	2 9 0 0 1 1 2 2 3 3 4 4 5 5 6 6 7 7 8 8 9 9	0 0 16 1 2 20 2 3 30 3 4 40 4 5 50 5 6 6 7 7 8 8 9 9	0 0 10 1 20 2 30 3 40 4 50 5 6 7 8 9	AM PM	0 0 0 0 1 1 2 2 3 3 4 5 6 7 8 9	9 98

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	c
	NO YES	In what month and year (since your last visit), was it [first] diagnosed?	How many times were you diagnosed with this since your last visit? FOR 9 OR MORE TIMES CODE "9"
<b>A. Kaposi's sarcoma</b>	NO YES <input type="radio"/> <input type="radio"/>	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>B. Pneumocystis carinii pneumonia (PCP)</b>	NO YES <input type="radio"/> <input type="radio"/>	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
<b>C. Other pneumonia, specify</b> <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 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 _____
<b>D. Toxoplasmosis</b>	NO YES <input type="radio"/> <input type="radio"/>	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>E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it?</b> 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 87 88 89 90 91 92 93 94 95 96 97 98	1 2 3 4 5 6 7 8 9
<b>F. Mycobacterial infection (MAC, MAI or atypical TB)</b>	NO YES <input type="radio"/> <input type="radio"/>	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



248334

## 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?
<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	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 87 88 89 90 91 92 93 94 95 96 97 98
<b>H. Cryptococcal meningitis</b>	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 87 88 89 90 91 92 93 94 95 96 97 98
<b>I. Candida in esophagus or lungs (not mouth)</b>	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 87 88 89 90 91 92 93 94 95 96 97 98
<b>J. Cryptosporidiosis</b>	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 87 88 89 90 91 92 93 94 95 96 97 98
<b>K. Wasting Syndrome</b>	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 87 88 89 90 91 92 93 94 95 96 97 98
<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	<input type="text"/> J F M A M J J A S O N D <input type="text"/> 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<sup>+</sup> T-cell count less than 200 (per  $\mu$ l) or a percentage less than 14%?CD4 LYMPHOCYTES = CD4<sup>+</sup> T-CELLS = HELPER T-CELLS

- No → SKIP TO Q 3  
 Yes

In what month and year were you first told?

<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D			
<input type="text"/>	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

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	b																										
<b>IF "YES": What was the diagnosis?</b>	<b>In what month and year was it first diagnosed since your last visit?</b>																										
1) Specify: _____	<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>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td></tr> </table>		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	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: _____	<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>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td></tr> </table>		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	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: _____	<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>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td></tr> </table>		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	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	b																																												
<b>IF YES: What kind of cancer did they say it was?</b>	<b>In what month and year was it first diagnosed since your last visit?</b>																																												
1) Site: _____ Type: _____	<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>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td></tr> </table>		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	F	M	A	M	J	J	A	S	O	N	D																																	
	87	88	89	90	91	92	93	94	95	96	97	98																																	
<table border="1"> <tr><td></td><td>0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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	
	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																																			
2) Site: _____ Type: _____	<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>87</td><td>88</td><td>89</td><td>90</td><td>91</td><td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td></tr> </table>		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	F	M	A	M	J	J	A	S	O	N	D																																	
	87	88	89	90	91	92	93	94	95	96	97	98																																	
<table border="1"> <tr><td></td><td>0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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	
	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																																			

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

GET MEDICAL RELEASE

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
		0	10	20	30								
DAY		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
		0	10	20	30								
DAY		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  
 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  Yes

REVIEW RESPONSE TO Q 4, IF DIAGNOSED WITH CANCER USE PROMPT  
 AND RE-ASK QUESTION, OTHERWISE 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 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?
<p>1) Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90  <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Name of doctor  <input type="text"/></p> <p>Name of hospital/center/clinic  <input type="text"/></p> <p>City _____ State _____ DATE _____</p>
<p>2) Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90  <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Name of doctor  <input type="text"/></p> <p>Name of hospital/center/clinic  <input type="text"/></p> <p>City _____ State _____ DATE _____</p>
<p>3) Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90  <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Specify:  <input type="text"/>  <input type="text"/>  <input type="text"/></p> <p><input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9</p>	<p>Name of doctor  <input type="text"/></p> <p>Name of hospital/center/clinic  <input type="text"/></p> <p>City _____ State _____ DATE _____</p>

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)]? NO YES

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) NO YES

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 NO YES

- C. Bronchitis NO YES

- 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? NO YES  
 [This includes going to the doctor for chronic hepatitis.]

IF YES: Was it:  Hepatitis A or infectious hepatitis    
 (Read and answer each.)

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? NO YES

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? NO YES

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

IF YES: What was the diagnosis?

Specify:

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

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

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

IF YES: What was the diagnosis?

Specify:

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

Specify:

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

Specify:

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

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

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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)? NO YES

C. Has there been a period [since your last visit in (MONTH)] when your (herpes) sores seemed to come more often, get worse or last longer than usual? NO YES

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

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		b		c		d		e	
	How about (EACH)? Did you have that at any time [since your visit in (MONTH)]?		Did that last for two weeks or longer?		And do you have that now?		Is this a new condition? IF NO, GO TO NEXT ROW		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"/>	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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98	
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"/>	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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98	
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"/>	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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 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)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 87 88 89 90 91 92 93 94 95 96 97 98	
11) Other HIV-related symptoms Specify: <input type="text"/>	<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 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.

- |                                     |  |
|-------------------------------------|--|
| <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 |

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 (Epiriv, 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 (Epopen)  
 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 <input type="radio"/> <input type="radio"/>																																		
2) Some other kind of hormone such as anabolic steroids, insulin or thyroxine	<input type="radio"/> <input type="radio"/>																																		
3) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/> <input type="radio"/>																																		
4) Medication taken by mouth for fungal infection	<input type="radio"/> <input type="radio"/>																																		
5) Medication taken by mouth for worms or parasites	<input type="radio"/> <input type="radio"/>																																		
6) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> <input type="radio"/>																																		
7) Antidepressants or mood elevators	<input type="radio"/> <input type="radio"/>																																		
8) Lithium	<input type="radio"/> <input type="radio"/>																																		
9) Acyclovir (Zovirax) for herpes	<input type="radio"/> <input type="radio"/>																																		
10) a. Other (SPECIFY in column b) <table border="1" data-bbox="129 641 388 708"> <tr><td><input type="text"/></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><input type="text"/></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><input type="text"/></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>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> <input type="radio"/> SKIP TO Q 20	Name: _____ Use for: _____
<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																									
b. Other (SPECIFY in column b) <table border="1" data-bbox="129 743 388 810"> <tr><td><input type="text"/></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><input type="text"/></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><input type="text"/></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>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> <input type="radio"/> SKIP TO Q 20	Name: _____ Use for: _____
<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																									
c. Other (SPECIFY in column b) <table border="1" data-bbox="129 845 388 912"> <tr><td><input type="text"/></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><input type="text"/></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><input type="text"/></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>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> <input type="radio"/> SKIP TO Q 20	Name: _____ Use for: _____
<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																									
d. Other (SPECIFY in column b) <table border="1" data-bbox="129 947 388 1014"> <tr><td><input type="text"/></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><input type="text"/></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><input type="text"/></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>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> <input type="radio"/> SKIP TO Q 20	Name: _____ Use for: _____
<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																									
e. Other (SPECIFY in column b) <table border="1" data-bbox="129 1050 388 1117"> <tr><td><input type="text"/></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><input type="text"/></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><input type="text"/></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>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9	<input type="radio"/> <input type="radio"/> SKIP TO Q 20	Name: _____ Use for: _____
<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																									

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

No  
 Yes

Q 21 HAS BEEN DELETED. SKIP TO Q 22.

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  
 Yes

SKIP TO Q 26

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)].

A. With how many different men (if any) have you had sexual intercourse [since your last visit in (MONTH)]?  
 READ DEFINITION OF INTERCOURSE.

MEN

B. With how many other men have you had sexual activity that did not include intercourse?

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

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

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		b													
	Did you do this/engage in this activity with your partner since your last visit?		How many men did you do that with [since your visit in (MONTH)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)													
1) You used your tongue to touch or lick his anus ("rimming").	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	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				

IF NO INTERCOURSE, SKIP TO Q 26.

2) You put your penis in his mouth. IF NONE, SKIP TO ITEM (5).	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	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				

  

3) With how many of those ___ partners had you used a condom every time for oral sex even if it broke, tore or slipped?			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	partners
IF MULTIPLE PARTNERS:			0	100	200	300	400	500	600	700	800	900				
IF ONE PARTNER: Did you use a condom every time for oral sex even if it broke, tore or slipped?	NO <input type="radio"/>	YES <input type="radio"/>	0	10	20	30	40	50	60	70	80	90				
			0	1	2	3	4	5	6	7	8	9				

  

4) You ejaculated/came into his mouth.	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	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				

5) You put your penis into your partner's rectum (anal insertive intercourse). IF NONE, SKIP TO ITEM (8).	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	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				

  

6) With how many of those ___ partners had you used a condom every time even if it broke, tore or slipped?			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	partners
IF MULTIPLE PARTNERS:			0	100	200	300	400	500	600	700	800	900				
IF ONE PARTNER: Did you use a condom every time even if it broke, tore or slipped?	NO <input type="radio"/>	YES <input type="radio"/>	0	10	20	30	40	50	60	70	80	90				
		SKIP TO ITEM 8	0	1	2	3	4	5	6	7	8	9				

  

7) With how many of these partners when you did not use a condom, had you ejaculated/come in his rectum?			<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	partners
IF MULTIPLE PARTNERS:			0	100	200	300	400	500	600	700	800	900				
IF ONE PARTNER: Did you ejaculate/come in his rectum when you did not use a condom?	NO <input type="radio"/>	YES <input type="radio"/>	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.

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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="checkbox"/></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><input type="checkbox"/></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><input type="checkbox"/></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	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9
<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900																									
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90																									
<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9																									
IF MULTIPLE PARTNERS: 9) How many of those ___ partners used a condom <u>every</u> time for oral sex even if it broke, tore or slipped?  IF ONE PARTNER: Did he use a condom <u>every</u> time for oral sex even if it broke, tore or slipped?	NO    YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="checkbox"/></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><input type="checkbox"/></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><input type="checkbox"/></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	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9
<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900																									
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90																									
<input type="checkbox"/>	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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="checkbox"/></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><input type="checkbox"/></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><input type="checkbox"/></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	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9
<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900																									
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90																									
<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9																									
IF MULTIPLE PARTNERS: 11) How many of those ___ partners used a condom <u>every</u> time even if it broke, tore or slipped?  IF ONE PARTNER: Did he use a condom <u>every</u> time even if it broke, tore or slipped?	NO    YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="checkbox"/></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><input type="checkbox"/></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><input type="checkbox"/></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	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9
<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900																									
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90																									
<input type="checkbox"/>	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		b				c	
	How about (EACH) Have you (taken/used) any [since your visit in (MONTH)]?		How often did you (use/take) (DRUG) [since your visit in (MONTH)]? Refer to page 5 in your booklet.				Did you (take/use) (DRUG) with a needle [since your visit in (MONTH)]?	
	NO	YES	DAILY	WEEKLY	MONTHLY	LESS OFTEN	NO	YES
Marijuana or hashish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Crack or cocaine that you smoke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other forms of cocaine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crystal, Methamphetamine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		
Other kinds of drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

Specify:

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?                    | <input type="radio"/> | <input type="radio"/> |
| D. Did you lose private health insurance coverage at any time since your last visit, even temporarily? | <input type="radio"/> | <input type="radio"/> |
| E. 1) Have you applied for private health insurance at any time since your last visit?                 | <input type="radio"/> | <input type="radio"/> |
| 2) IF YES: Have you been refused health insurance coverage at any time since your last visit?          | <input type="radio"/> | <input type="radio"/> |

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

SKIP TO Q 29

- B. If YES, was that change your choice?  NO  YES
- C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION]
- |  | NO                    | YES                   |
|--|-----------------------|-----------------------|
| 1) Lost or quit job  | <input type="radio"/> | <input type="radio"/> |
| 2) Changed job (employer or employment status)                       | <input type="radio"/> | <input type="radio"/> |
| 3) Employer changed or dropped coverage                              | <input type="radio"/> | <input type="radio"/> |
| 4) Pre-existing medical condition limited choices                    | <input type="radio"/> | <input type="radio"/> |
| 5) To be able to choose doctors or providers                         | <input type="radio"/> | <input type="radio"/> |
| 6) More or better coverage of needed or desired services             | <input type="radio"/> | <input type="radio"/> |
| 7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed | <input type="radio"/> | <input type="radio"/> |
| 8) Financial reasons (cost of premiums, co-payments or deductibles)  | <input type="radio"/> | <input type="radio"/> |
| 9) Eligible for Medicare   | <input type="radio"/> | <input type="radio"/> |

- 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	<input type="radio"/>	<input type="radio"/>
2) Only eligible for current coverage due to medical condition	<input type="radio"/>	<input type="radio"/>
3) To be able to choose doctors or providers	<input type="radio"/>	<input type="radio"/>
4) To have more or better coverage of needed or desired services	<input type="radio"/>	<input type="radio"/>
5) Eligible for Medicaid, Medi-Cal, or Medical Assistance	<input type="radio"/>	<input type="radio"/>
6) Financial reasons (cost of premiums, co-payments or deductibles)	<input type="radio"/>	<input type="radio"/>
7) Eligible for Medicare	<input type="radio"/>	<input type="radio"/>

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

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		b	
	Have you used (EACH) since your last visit?		How many times? (99 = 99 or more)	
1) HMO	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
2) Doctor's office (non-HMO)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
3) Any clinic	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
4) Emergency room	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
5) Other outpatient	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>

Specify:

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



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)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<table border="1"> <tr> <td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	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)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<table border="1"> <tr> <td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	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)	<input type="radio"/> NO GO TO NEXT ROW  <input type="radio"/> YES	<table border="1"> <tr> <td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	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)	<input type="radio"/> NO GO TO Q 36  <input type="radio"/> YES	<table border="1"> <tr> <td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	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]

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



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	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	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

