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.

CORRECT MARK INCORRECT MARKS

ID NUMBER	VISIT NO.	TIME BEGAN (HR, MIN)	DATE (MONTH, DAY, YEAR)
	3 6	AM / PM	Jan, Feb, Mar, Apr, May, June, July, Aug, Sept, Oct, Nov, Dec; YEAR: 01, 02

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 or KS	NO (GO TO NEXT ROW) / YES	J F M A M J J A S O N D; 91 92 93 94 95 96 97 98 99 00 01 02	
B. Pneumocystis carinii pneumonia (PCP)	NO (GO TO NEXT ROW) / YES	J F M A M J J A S O N D; 91 92 93 94 95 96 97 98 99 00 01 02	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; 91 92 93 94 95 96 97 98 99 00 01 02	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 or Toxo infection	NO (GO TO NEXT ROW) / YES	J F M A M J J A S O N D; 91 92 93 94 95 96 97 98 99 00 01 02	
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; 91 92 93 94 95 96 97 98 99 00 01 02	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; 91 92 93 94 95 96 97 98 99 00 01 02	

GET MEDICAL RELEASE

PLEASE DO NOT WRITE IN THIS AREA

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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?
	NO	YES	
G. Lymphoma, specify ◯ Primary brain lymphoma ◯ Non-Hodgkin's ◯ Other Specify:	◯ GO TO NEXT ROW	◯	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
H. Meningitis related to HIV or cryptococcal meningitis	◯ GO TO NEXT ROW	◯	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
I. Candida or thrush, a yeast infection of the esophagus, not just your mouth	◯ GO TO NEXT ROW	◯	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
J. Cryptosporidiosis	◯ GO TO NEXT ROW	◯	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
K. Wasting Syndrome or severe weight loss	◯ GO TO Q 2	◯	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02

c What was the name and address of the physician who diagnosed the condition(s)?

Name of hospital/clinic or doctor

Address

City State

2. [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 3**
◯ 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 91 92 93 94 95 96 97 98 99 00 01 02
2) Specify:	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
3) Specify:	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02

GET MEDICAL RELEASE

3. [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 4
- Yes

a. IF YES: What kind of cancer did they say it was?

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

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

b. In what month and year was it first diagnosed since your last visit?

1)

	J	F	M	A	M	J	J	A	S	O	N	D
	91	92	93	94	95	96	97	98	99	00	01	02

2)

	J	F	M	A	M	J	J	A	S	O	N	D
	91	92	93	94	95	96	97	98	99	00	01	02

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

GET MEDICAL RELEASE

The next few questions are about tuberculosis or TB for short.

	NO	YES
4.A. [Since your last visit in (MONTH)] did you have a skin test for TB, sometimes called a PPD?	○ SKIP TO Q 5	○
B. IF YES: When was your last test?		
C. Was it positive?	○	○

	J	F	M	A	M	J	J	A	S	O	N	D
	91	92	93	94	95	96	97	98	99	00	01	02

	NO	YES
5.A. [Since your last visit in (MONTH)] have you had an active TB infection?	○ SKIP TO Q 6	○
B. Was the TB in your lungs?	○	○
C. Was the TB in any other part of your body (other than your lungs)?	○	○

GET MEDICAL RELEASE

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

- ◯ No → **SKIP TO Q 7**
- ◯ 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		91	92	93	94	95	96	97	98	99	00	01	02

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 6.A.), SKIP TO QUESTION 7

(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		91	92	93	94	95	96	97	98	99	00	01	02

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

6.B. 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 7**
- ◯ Yes

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

7. 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				
	87	88	89	90	91	92	93	94	95	96	97	98	99	00	01	02

→ Before 1988

8.A. We are now going to ask you about specific conditions that may have been diagnosed in either your immediate family or yourself. Immediate family includes your biological mother, father, brothers and sisters.

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.B. Have any members of your immediate family ever suffered from (EACH)?

	NO	YES	DON'T KNOW
1. High blood pressure or hypertension	◯	◯	◯
2. Pancreatitis	◯	◯	◯
3. Diabetes or high blood sugar	◯	◯	◯
4. Chest pain related to heart disease	◯	◯	◯
5. Heart attack before age 60	◯	◯	◯
6. Stroke	◯	◯	◯
7. High blood cholesterol or high lipids	◯	◯	◯
8. Hip fracture or broken hip before age 60	◯	◯	◯
9. Cancer	◯	◯	◯
	SKIP TO Q 9		SKIP TO Q 9

IF YES: Was it:

	NO	YES	DON'T KNOW
a. Skin cancer	◯	◯	◯
b. Colon cancer	◯	◯	◯
c. Prostate cancer	◯	◯	◯
d. Other cancer	◯	◯	◯

Specify:

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

◯ No → REVIEW RESPONSE TO Q 3, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 10

◯ 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 Where in your body?	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: 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	Name of doctor Name of hospital/center/clinic City State DATE
2)	Specify: 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	Name of doctor Name of hospital/center/clinic City State DATE
3)	Specify: 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	Name of doctor Name of hospital/center/clinic City State DATE

GET MEDICAL RELEASE

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

	NO	YES
A. Shingles (or herpes zoster)	○	○

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

86 87 88 89 90 91 92 93 94 95 96 97 98 99 00 01 02

	NO	YES
B. Thrush (yeast in your mouth)	○	○

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

J F M A M J J A S O N D

91 92 93 94 95 96 97 98 99 00 01 02

	NO	YES
C. Infectious mononucleosis	○	○
D. Sinusitis, a sinus infection that requires antibiotics	○	○
E. Bronchitis	○	○
F. Pancreatitis	○	○
G. High blood pressure or hypertension	○	○
H. Injury to head with loss of consciousness	○	○
I. Chest pain or angina	○	○
J. Heart attack	○	○
K. Congestive heart failure or CHF	○	○
L. Stroke or CVA	○	○
M. Seizure	○	○
N. Osteoporosis (bone thinning)	○	○
O. Kidney disease	○	○
P. Arthritis	○	○

GET MEDICAL RELEASE

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

	NO	YES
Rheumatoid	○	○
Osteoarthritis or degenerative	○	○
Other	○	○
Don't know		○

Specify:

	NO	YES
Q. Avascular necrosis or had a hip replacement	○	○
R. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis.]	○	○

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

	NO	YES
Hepatitis A or infectious hepatitis	○	○
Hepatitis B or serum hepatitis	○	○
Hepatitis C	○	○
Other	○	○
Don't know		○

Specify:

	NO	YES
S. Liver disease	○	○

GET MEDICAL RELEASE

IF YES: Was it:

	NO	YES
Cirrhosis	○	○
Fibrosis	○	○
Inflammation	○	○
Elevated liver function test/enzyme	○	○
Other	○	○
Don't know		○

Specify:

	NO	YES
T. [Since your last visit in (MONTH)] Have you received an injection of pneumococcal vaccine/Pneumovax?	○	○
U. [Since your last visit in (MONTH)] Have you received an injection of hepatitis B vaccine?	○	○
V. Have you ever received an injection of hepatitis A vaccine?	○	○
W. Has a doctor or other medical practitioner ever told you that you had sickle cell anemia?	○	○
X. [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

Y. [Since your last visit in (MONTH)] Have you seen a doctor or other medical practitioner for any (other) conditions or problems in the following areas?

	NO	YES
a) Affecting the whole body	○	○

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
b) Eyes	○	○

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

Y. Continued

	NO	YES
c) Ears, Nose, Throat, Mouth	○	○

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
d) Heart	○	○

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
e) Lungs	○	○

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
f) Stomach and Intestines	○	○

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
g) Bones, Joints or Muscles	○	○

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) Genital and Urinary	○	○

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
i) Skin	○	○

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
j) Nervous system	○	○

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
k) Psychological	○	○

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
l) Hormones	○	○

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
m) Blood and Fluids	○	○

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
n) Allergy and Immune system	○	○

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
o) Other	○	○

IF YES: What was the diagnosis?

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

11.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 12

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? ◯ ◯

12. 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) Chlamydia	◯	◯
I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis	◯	◯

Specify:

13.A. [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 91 92 93 94 95 96 97 98 99 00 01 02
2) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
3) Diarrhea for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
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 91 92 93 94 95 96 97 98 99 00 01 02
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 91 92 93 94 95 96 97 98 99 00 01 02
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 91 92 93 94 95 96 97 98 99 00 01 02
7) Drenching sweats at night on at least 3 occasions	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
8) Joint pain	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
9) Ascites (fluid buildup in the stomach or abdomen)	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
10) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
11) 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 91 92 93 94 95 96 97 98 99 00 01 02
12) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	○	○			○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
13) Anemia, low RBC, low hemoglobin	○	○			○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
14) Unusual bleeding or bleeding that is difficult to stop	○	○			○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
15) Persistent dizziness for at least 3 consecutive days	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02

13.A. Continued

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)
16) Nausea, vomiting	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
17) Abdominal pain, bloating, cramps	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
18) Muscle pain or weakness	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
19) Kidney stones	○	○			○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
20) High blood sugar, diabetes	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
21) High cholesterol, high triglycerides or high lipids	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
22) Painful urination	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
23) Fat maldistribution or abnormal changes in body fat	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
24) Vivid nightmares or dreams	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
25) Insomnia or problems sleeping	○	○	○	○	○	○	○	○	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02

13.B. [Since your last visit in (MONTH)]
Have you experienced:

If NO, go to next question.
If YES, indicate severity.

Severity
(0= None, 1= Mild, 10= Severe)

	NO	YES		Severity
1. Pain, aching, or burning in your feet or legs?	○	○	Right	0 1 2 3 4 5 6 7 8 9 10
			Left	0 1 2 3 4 5 6 7 8 9 10
2. Pins and needles in your feet or legs?	○	○	Right	0 1 2 3 4 5 6 7 8 9 10
			Left	0 1 2 3 4 5 6 7 8 9 10
3. Numbness (lack of feeling) in your feet or legs?	○	○	Right	0 1 2 3 4 5 6 7 8 9 10
			Left	0 1 2 3 4 5 6 7 8 9 10

14. A. [Since your visit in (MONTH)] Has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs?

- ◯ No → SKIP TO Q 15
- ◯ Yes

B. What type of test was done?

	NO	YES	DON'T KNOW
1) Phenotype	◯	◯	◯
2) Genotype	◯	◯	◯

C. Has your treatment (drugs) been changed as a result of that test?

- ◯ No
- ◯ Yes
- ◯ Don't know

15. Since your last visit, have you taken any HIV-related medications or treatments? (That is, medications or treatments to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS.)

- ◯ No
- ◯ Yes → SKIP TO Q 15.B (1)

15.A. IF NO: Why did you decide not to take HIV-related medications?

READ EACH, MARK ALL THAT APPLY

- ◯ Not infected with HIV → SKIP TO Q 16
- ◯ Doctor said was not necessary
- ◯ Not sick
- ◯ Too expensive
- ◯ Don't think they work or will help
- ◯ Possible side effects
- ◯ Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
- ◯ Other reason

Specify:

SKIP TO Q 16

15.B. (1) [Since your last visit (MONTH)] Have you taken any medication or drug on this list [SHOW LIST 1 AND MEDICATION PHOTO CARDS]?

- ◯ No
- ◯ Yes → SKIP TO Q 15.B (3)

(2) IF NO: Why did you decide not to take HIV-related medications?

READ EACH, MARK ALL THAT APPLY

- ◯ Doctor said was not necessary
- ◯ Not sick
- ◯ Too expensive
- ◯ Don't think they work or will help
- ◯ Possible side effects
- ◯ Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
- ◯ Other reason

Specify:

SKIP TO Q 15.C

15.B. (3) Please name those drugs that you have taken or show me which ones.

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

- ◯ 3-TC (Epivir, Lamivudine)
- ◯ Abacavir (Ziagen)
- ◯ Amprenavir (Agenerase)
- ◯ AZT (Retrovir, Zidovudine)
- ◯ Atazanavir (BMS-232632)
- ◯ Combivir (AZT & 3-TC)
- ◯ d4T (Zerit, Stavudine)
- ◯ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ◯ ddI (dideoxyinosine, Didanosine, Videx)
- ◯ Delavirdine
- ◯ Efavirenz (Sustiva)
- ◯ Indinavir (Crixivan)
- ◯ Lopinavir/r (Kaletra)
- ◯ Nelfinavir (Viracept)
- ◯ Nevirapine (Viramune)
- ◯ Ritonavir (Norvir)
- ◯ Saquinavir (Invirase, Fortovase)
- ◯ Tenofovir
- ◯ Trizivir (abacavir + zidovudine + lamivudine)
- ◯ T-20
- ◯ Other anti-viral from Drug List 1

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) [Since your last visit (MONTH)], did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?

- ◯ No → SKIP TO Q 15.C
- ◯ Yes

IF YES: How many times did this occur?

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

Did your physician prescribe or agree to any of these?

◯ No ◯ Yes

For how many days did you stop during the last time?

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

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B(3)

15.C. (1) [Since your last visit in (MONTH)] Have you taken any medication or drug on this list [SHOW LIST 2] to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- ◯ No → SKIP TO Q 15.D
- ◯ 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)
- ◯ Co-enzyme Q
- ◯ Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
- ◯ Dapsone
- ◯ DHEA
- ◯ Ethambutol
- ◯ Erythropoietin (Epogen)
- ◯ Flagyl (metronidazole)
- ◯ Fluconazole (Diflucan)
- ◯ Ganciclovir (DHPG)
- ◯ Hydroxyurea (Hydrea)
- ◯ Interleukin-2 (IL-2)
- ◯ Itraconazole
- ◯ Ketoconazole (Nizoral)
- ◯ Megace
- ◯ Mycelex (clotrimazole)
- ◯ NAC (N-acetyl-cysteine)
- ◯ Nandralone (Deca-Durabolin)
- ◯ Nystatin (Mycostatin)
- ◯ Oxandrin
- ◯ Pentamidine (aerosolized)
- ◯ Rifabutin (Ansamycin, Mycobutin)
- ◯ Testosterone (Delatestryl, Virilon)
- ◯ Vaccine trial (generic)
- ◯ Other from Drug List 2

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 15.C(1)

D. (1) [Since your last visit in (MONTH)] Have you taken any medication, drug or other therapy that was not listed to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- ◯ No → SKIP TO Q 16
- ◯ 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

16. 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 15a) / IF "NO" TO a GO TO NEXT ITEM	a How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]? NO / YES	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?
1) Steroids that you took by mouth or were injected	◯ NO ◯ YES	Name: / Used for:
2) Thyroid hormone or medication	◯ ◯	Name:
3) Other hormones such as anabolic steroids	◯ ◯	Name: / Used for:
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	◯ ◯	Name: / Used for:
5) Medication taken by mouth for fungal infection	◯ ◯	Name:
6) Medication taken by mouth for worms or parasites	◯ ◯	Name:
7) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? ◯ No ◯ Yes	◯ ◯	Name: / Used for:
8) Antidepressants or mood elevators	◯ ◯	Name:
9) Lithium	◯ ◯	Used for:
10) Acyclovir, famciclovir or valacyclovir for herpes IF YES, was this for: chronic herpes? ◯ No ◯ Yes episodic herpes? ◯ No ◯ Yes	◯ ◯	Name:
11) Viagra	◯ ◯	Used for:
12) Cholesterol, triglycerides or lipid lowering medications a. (SPECIFY in column b) →	◯ ◯ SKIP TO Q 16.13	Name:
b. (SPECIFY in column b) →	◯ ◯ SKIP TO Q 16.13	Name:
13) Medications used for diabetes a. (SPECIFY in column b) →	◯ ◯ SKIP TO Q 16.14	Name:
b. (SPECIFY in column b) →	◯ ◯ SKIP TO Q 16.14	Name:

Code grid (for each of 12a, 12b, 13a, 13b):

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

16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a) / IF "NO" TO a GO TO NEXT ITEM	a How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?
14) Hepatitis medications	NO / YES	
a. (SPECIFY in column b) → 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	◯ SKIP TO Q 16.15 ◯	Name:
b. (SPECIFY in column b) → 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	◯ SKIP TO Q 16.15 ◯	Name:
15) a. Other (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
b. Other (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
c. (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
d. Other (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
e. (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
f. Other (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
g. (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:
h. Other (SPECIFY in column b) → 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	◯ SKIP TO Q 17 ◯	Name: / Used for:

17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?

◯ No **SKIP TO Q 18** ◯ Yes

B. Do you know the name of the trial?

◯ No ◯ Yes → Specify: ____________

	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. Where did you go for this trial?

Name of hospital or clinic

Address

City State

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

18.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

18.B. Do you have insurance coverage that pays for all or some of your medications? NO ◯ YES ◯

IF NO TO Q 18.A (1)–(8) AND Q 18.B, THEN SKIP TO Q 22

19. A. Since your last visit, have you changed or lost your medical coverage? NO ◯ (**SKIP TO Q 21**) YES ◯

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	◯	◯
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 19.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

19.E. Are you currently insured?

- ◯ No → SKIP TO Q 22
- ◯ Yes

20.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 Q20.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

21. 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

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

- ◯ No
- ◯ Yes

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

- ◯ HMO
- ◯ Doctor's office (non-HMO) including Urgent Care
- ◯ Any clinic
- ◯ Emergency room
- ◯ Other outpatient

Specify: ____________________

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

24. 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? NO	YES	b. How many times? (99 = 99 or more)
1) HMO	◯ GO TO NEXT ROW	◯	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) including Urgent Care	◯ GO TO NEXT ROW	◯	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
3) Any clinic	◯ GO TO NEXT ROW	◯	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
4) Emergency room	◯ GO TO NEXT ROW	◯	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9
5) Other outpatient	◯ GO TO Q 25	◯	0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9

Specify: ____________________

25. 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 26 ◯ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

26. **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

27.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 28**
- 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 28
- Yes → Why did you not obtain prescription medications?

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

Specify:

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

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

30. **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
- 50,000–59,999
- 60,000 or more
- Does not wish to answer

31. **Are you experiencing major financial difficulty meeting your basic expenses?**
- No → **SKIP TO Q 32**
- Yes

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

32. **Since your last visit, has your employment status changed for any reason related to HIV disease?**
- No → **SKIP TO Q 33**
- 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:

I am going to ask you a series of questions about specific behaviors, including cigarette smoking, alcohol use, sexual behavior, and recreational drug use.

33. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes?

- ◯ No → SKIP TO Q 34
- ◯ Yes

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

- ◯ No → SKIP TO Q 34
- ◯ Yes
- ◯ Occasionally (less than one cigarette per day) → SKIP TO Q 34

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

34. The next questions are about alcoholic beverages—that is, wine, beer or liquor you've drunk [since your visit in (MONTH)].

A. Did you drink any alcoholic beverages [since your visit in (MONTH)]?

- ◯ No → SKIP TO Q 35
- ◯ Yes

34.B. How often do you have 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

C. [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

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35. 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 38
- ◯ 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 36A and B, DO NOT ask Q 36C].

◯ **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 36C asking for women only and then skip to Q 38.

◯ **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.

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

MEN		WOMEN
A. With how many different men (if any) have you had sexual intercourse [since your last visit in (MONTH)]? READ DEFINITION OF INTERCOURSE.	B. With how many other men have you had sexual activity that did not include intercourse?	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	0 100 200 300 400 500 600 700 800 900	0 100 200 300 400 500 600 700 800 900
0 10 20 30 40 50 60 70 80 90	0 10 20 30 40 50 60 70 80 90	0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9	0 1 2 3 4 5 6 7 8 9

37. 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 / 0 1 2 3 4 5 6 7 8 9 partners

IF NO INTERCOURSE, SKIP TO Q 38.

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

37. 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?)
6) He put his penis in your mouth. 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 / 0 1 2 3 4 5 6 7 8 9 partners
7) IF MULTIPLE PARTNERS: 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 / 0 1 2 3 4 5 6 7 8 9 partners

8) He put his penis in your rectum (anal receptive intercourse). IF NONE, SKIP TO Q 38).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 / 0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9 partners
9) IF MULTIPLE PARTNERS: 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 / 0 1 2 3 4 5 6 7 8 9 partners

38. 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	
Pot, Marijuana or Hash	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 ○
Speed, Meth or Ice	NO (GO TO NEXT ROW) ○ YES ○	○	○	○	○	NO ○ YES ○
Heroin	NO (GO TO NEXT ROW) ○ YES ○	○	○	○	○	NO ○ YES ○
Speedball (heroin and cocaine together)	NO (GO TO NEXT ROW) ○ YES ○	○	○	○	○	NO ○ YES ○
Ecstasy, XTC, X or MDMA	NO (GO TO NEXT ROW) ○ YES ○	○	○	○	○	
Other kinds of street/club drugs	NO (GO TO Q 39) ○ YES ○					
Specify: ___ 0 1 2 3 4 5 6 7 8 9		○	○	○	○	NO ○ YES ○
Specify: ___ 0 1 2 3 4 5 6 7 8 9		○	○	○	○	NO ○ YES ○
Specify: ___ 0 1 2 3 4 5 6 7 8 9		○	○	○	○	NO ○ YES ○
Specify: ___ 0 1 2 3 4 5 6 7 8 9		○	○	○	○	NO ○ YES ○

IF "YES" TO ANY ITEM IN COLUMN (C), SKIP TO Q 39.B

39. A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?

- No → SKIP TO Q 45
- Yes

B. Were any of these times that you injected recreational drugs in a shooting gallery?

- No
- Yes

C. Do you currently inject drugs?

- No
- Yes

D. Thinking about the period when you injected the most, how many times did you inject [DRUG] per month?

Speedball (cocaine and heroin together)

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

Cocaine by itself

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

Heroin by itself

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

Speed by itself

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

40. [Since your last visit in (MONTH)] have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?

- No → SKIP TO Q 42
- Yes

41. A. [Since your last visit in (MONTH)] how many times have you used needles or works that were first used by someone else and then passed to you?

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

B. With how many different people?

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

42. A. [Since your last visit in (MONTH)] have you shared water to rinse your needles with anyone?

- No → SKIP TO Q 43
- Yes

B. How many times?

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

C. With how many different people?

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

43. [Since your last visit in (MONTH)] how often did you clean your works with bleach?

- Never
- Less than half the time
- About half the time
- Most of the time
- Always

44. A. [Since your last visit in (MONTH)] have you participated in a needle exchange program?

- No → SKIP TO Q 45
- Yes

B. Of the times you obtained needles, how often did you get them from a needle exchange?

- Less than half the time
- Half the time
- Most of the time
- Always

C. Do you have another source of clean needles?

- No
- Yes

45. [Since your last visit in (MONTH)] have you been in a drug treatment program, including inpatient and/or outpatient detox, methadone maintenance programs, halfway houses, narcotics anonymous, prison or jail-based programs and/or any other program?

- No
- Yes

46.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 47**
- ◯ Yes

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

47. **Telephone interview?**

- ◯ No
- ◯ Yes

48. **Home visit?**

- ◯ No
- ◯ Yes

49. **PWA interview?**

- ◯ No
- ◯ Yes
- ◯ Don't know

50. **Returning censored participant?**

- ◯ No
- ◯ Yes

51. 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	

52. 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

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