FOLLOW-UP VISIT SECTION 4

Effective January 18, 2011, the variable visit number suffix was changed from 2 digits (i.e., VARIABLE_54) to a 3 digit suffix (i.e., VARIABLE_054) and affects ALL visit questionnaire variables from the first visit onward.

- 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	TIME BEGAN MIN	DATE MONTH	DATE DAY	DATE YEAR
MACSID	4 5 0	S4TBH_45	S4TBM_45	DAT4M_45	DAT4D_45	DAT4Y_45
	VISIT_45		S4TBZ_45			

1. Let's start with some medical conditions. Since your last visit [in (MONTH, YEAR)], were you diagnosed with some form of cancer, including Kaposi's sarcoma, non-Hodgkin's lymphoma, primary brain lymphoma, or Castleman's disease?

○ No → IF "NO," GO TO Q 2

○ Yes

CANCD_45

a IF YES: Where in the body was the cancer (Castleman's disease) and what kind of cancer did they say it was?

b In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?

1) Site / Type — CAN1T_45 — CAN1M_45 — CAN1Y_45

2) Site / Type — CAN2T_45 — CAN2M_45 — CAN2Y_45

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

Name of hospital/clinic or doctor

Address

City State

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

Name of hospital/clinic or doctor

Address

City State

GET MEDICAL RELEASE

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PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

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2. Since your last visit [in (MONTH, YEAR)], were you diagnosed with any AIDS-related illnesses other than Kaposi's sarcoma, non-Hodgkin's lymphoma or primary brain lymphoma?

- ◯ No → IF "NO," GO TO Q 3
- ◯ Yes

AID_45

a IF YES: What was the diagnosis?

b In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?

1) Type

AIDT1_45

AIDM1_45
AIDY1_45

2) Type

AIDT2_45

AIDM2_45
AIDY2_45

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

Name of hospital/clinic or doctor

Address

City State

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

Name of hospital/clinic or doctor

Address

City State

3. Since your last visit [in (MONTH, YEAR)], were you diagnosed with pneumonia?

- ◯ No → IF "NO," GO TO Q 4
- ◯ Yes

PNEUM_45

a In what month and year since your last visit [in (MONTH, YEAR)] was it first diagnosed?

MPNEU_45
PNEUY_45

b What was the name and address of the physician who diagnosed the condition?

Name of hospital/clinic or doctor

Address

City State

GET MEDICAL RELEASE

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

4.A. Since your last visit [in (MONTH, YEAR)], did you have a skin test for TB, sometimes called a PPD? PPDV_45 — NO ◯ YES ◯ — SKIP TO Q 5

B. IF YES: When was your last test? PPDM_45 PPDY_45

	J	F	M	A	M	J	J	A	S	O	N	D
	95	96	97	98	99	00	01	02	03	04	05	06

C. Was it positive? PSPPD_45 — NO ◯ YES ◯

GET MEDICAL RELEASE

5.A. Since your last visit [in (MONTH, YEAR)] have you had an active TB infection? TBDXE_45 — ◯ ◯ — SKIP TO Q 6

B. Was the TB in your lungs? TBILG_45 — ◯ ◯

C. Was the TB in any other part of your body (other than your lungs)? TBOLG_45 — ◯ ◯

6.A. Since your last visit [in (MONTH, YEAR)], have you been admitted to the hospital for any reason? This includes overnight stays and outpatient procedures. HOSP_45

◯ No → SKIP TO Q 7

◯ Yes → How many separate times were you a patient in a hospital since your last visit [in (MONTH, YEAR)]? NHOSP_45

	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. IF HOSPITALIZED FOR CV CONDITION, REQUEST FULL HOSPITAL RECORDS. SEE GUIDELINES FOR SPECIFIC INSTRUCTIONS.

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B. Tell me about (that hospitalization/outpatient procedure/each of those times) starting with the most recent hospitalization/outpatient procedure.

(1) a. On what date did you last go into the hospital? HOS1M_45 HOS1D_45 HOS1Y_45

		J	F	M	A	M	J	J	A	S	O	N	D
MO													
DAY		0	10	20	30								
		0	1	2	3	4	5	6	7	8	9		
YEAR		95	96	97	98	99	00	01	02	03	04	05	06

b. How many nights did you spend in the hospital at that time? **IF OUTPATIENT: FILL IN ZERO.** HOS1N_45

	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.**

What was the name and address of the physician who diagnosed the condition(s)?
IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Name of hospital/clinic or doctor

Address

City State

1) Diagnosis — TYHO11_45 H1DX1_45

V	E
0	1M 2M 3M .M
0	100 200 300 00
0	10 20 30 40 50 60 70 80 90
0	1 2 3 4 5 6 7 8 9

2) Diagnosis — TYHO12_45 H1DX2_45

V	E
0	1M 2M 3M 9M
0	100 200 300 900
0	10 20 30 90
0	1 2 3 4 5 6 7 8 9

IF ONLY ONE HOSPITALIZATION (SEE RESPONSE TO 6.A.), SKIP TO QUESTION 7

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(2) a. For your second most recent time to the hospital, 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		95 96 97 98 99 00 01 02 03 04 05 06

HOS2M_45
HOS2D_45
HOS2Y_45

b. How many nights did you spend in the hospital at that time? **IF OUTPATIENT: FILL IN ZERO.**

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

NIGHTS

HOS2N_45

c. For what condition or problem were you hospitalized and the name/address of the hospital?
RECORD FULLY IN R's OWN WORDS.

What was the name and address of the physician who diagnosed the condition(s)?
IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Name of hospital/clinic or doctor

Address

City State

1) Diagnosis

V E

0 1M 2M 3 M 9M
0 100 200 3 00 900
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9

TYHO21_45
H2DX1_45

2) Diagnosis

V E

0 1M 2M 3 M 9M
0 100 200 3 900
0 10 20 3 90
0 1 2 3 4 5 6 7 8 9

TYHO22_45
H2DX2_45

d. Did you have another prior hospitalization/outpatient procedure since your last visit [in (MONTH, YEAR)]?

- ◯ No → **SKIP TO Q 7**
- ◯ Yes

PHOS2_45

◯ **IF MORE THAN 2 HOSPITALIZATIONS/OUTPATIENT PROCEDURES SINCE YOUR LAST VISIT [IN (MONTH, YEAR)], MARK HERE AND USE CONTINUATION SHEET.**

7. Since your last visit [in (MONTH, YEAR)], have you been hospitalized, prescribed medication, or consulted a mental health professional for treatment of depression?

- ◯ No
- ◯ Yes
- ◯ Don't know

DEPR_45

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

	J F M A M J J A S O N D
	95 96 97 98 99 00 01 02 03 04 05 06

DEPRM_45
DEPRY_45

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

Since your last visit [in (MONTH, YEAR)], have any members of your immediate blood-related family been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?

- ◯ No
- ◯ Yes
- ◯ Don't know
- ◯ Not applicable (For those participants who do not have living blood-related family members or do not know them because they are adopted.) → **SKIP TO Q 9.A.(1)**

DEPRR_45

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8.B. Since your last visit [in (MONTH, YEAR)], have any members of your immediate family been diagnosed with...

	NO	YES	DON'T KNOW	
a. high blood pressure or hypertension?	○	○	○	HYPTR_45
b. angina, which often causes chest pain?	○	○	○	CPHDR_45
c. a heart attack or myocardial infarction (MI) before age 55?	○	○	○	HRATR_45
d. congestive heart failure or CHF?	○	○	○	CHFR_45
e. a stroke or CVA?	○	○	○	STROR_45
f. mini-strokes or transient ischemic attacks (TIA)?	○	○	○	TIAR_45
g. high cholesterol, high triglycerides, high lipids or too much fat in their blood?	○	○	○	HYPER_45
h. high blood sugar or diabetes?	○	○	○	DIABR_45

8.C. Since your last visit [in (MONTH, YEAR)], have any members of your immediate family been diagnosed with cancer?

○ No ○ Yes ○ Don't Know → SKIP TO Q 9.A.(1)

→ SKIP TO Q 9.A.(1)

CANCR_45

IF YES: Was it:

	NO	YES	DON'T KNOW	
a. Skin cancer	○	○	○	SCANR_45
b. Colon cancer	○	○	○	CCANR_45
c. Prostate cancer	○	○	○	PCANR_45
d. Cervical cancer (female family members)	○	○	○	VCANR_45
e. Anal cancer	○	○	○	ACANR_45
f. Other cancer	○	○	○	OCANR_45

Specify:

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9.A.(1) Since your last visit [in (MONTH, YEAR)], have you become aware of any anal cancer screening (testing involving an anal pap smear, collecting a swab, or possible anal biopsy) available in your community?

○ No
○ Yes
○ Don't know

ACSCM_45

(2) How likely is it that you will be screened for anal cancer, anal warts or another anal health problem in the next 6 months (outside of your regular MACS visit(s))?

○ Not at all likely
○ Unlikely
○ Possibly
○ Likely
○ Very likely

ACSL_45

(3) If you suspected that you had anal warts or another anal health problem, where would you go for diagnosis and/or treatment?

○ My primary physician
○ An STD clinic
○ A Gay clinic or health center
○ An anal specialist (proctologist or colorectal surgeon)
○ A dermatologist
○ An HIV specialist
○ Other → Specify:

ACSD_45

(4) How concerned are you about developing anal cancer at some point in your lifetime?

○ Not at all
○ Slightly
○ Moderately
○ Fairly
○ Very

ACCON_45

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9.B.(1) Since your last visit [in (MONTH, YEAR)], have you undergone an anal pap smear? (A doctor or medical practitioner took a swab of the anal canal to test for cancer cells.)

- ◯ No → GO TO Q 9.C.(1)
- ◯ Yes
- ◯ Don't Know → GO TO Q 9.C.(1)

APAPS_45

(2) In what month and year did you have the pap smear performed?

	J	F	M	A	M	J	J	A	S	O	N	D
	95	96	97	98	99	00	01	02	03	04	05	06

PAPSM_45
PAPSY_45

(3) Were the results abnormal?

- ◯ No → GO TO Q 9.C.(1)
- ◯ Yes → GET MEDICAL RELEASE

ABRAP_45

Name of the doctor who performed the pap smear and where it was performed.

Name of doctor

Name of hospital/center/clinic

City State

9.C.(1) Since your visit [in (MONTH, YEAR)], have you had any biopsies of the skin, anus, rectal area or other tissues and organs? By a biopsy, we mean removal of any tissue or gland to study under a microscope.

- ◯ No → REVIEW RESPONSE TO Q 1, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 10
- ◯ Yes

BIOPS_45

(2) How many times have you had a biopsy since your last visit [in (MONTH, YEAR)]?

	1	2	3	4	5	6	7	8	9

TIMES

NBIOP_45

(3) 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: BIOP1_45	Specify: BIDX1_45	Name of doctor Name of hospital/center/clinic City State DATE
2) Specify: BIOP2_45	Specify: BIDX2_45	Name of doctor Name of hospital/center/clinic City State DATE
3) Specify: BIOP3_45	Specify: BIDX3_45	Name of doctor Name of hospital/center/clinic City State DATE

GET MEDICAL RELEASE

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10. I am now going to ask you about other conditions, ailments or disorders. Were you diagnosed with any of the following since your last visit [in (MONTH, YEAR)]? This includes new episodes or recurrences of chronic conditions.

	NO	YES
A. Shingles		HERPZ_45
B. Thrush (yeast in your mouth)		THRSH_45
C. Sinusitis, a sinus infection that requires antibiotics		SINUS_45
D. Bronchitis		BRONC_45
E. Pancreatitis		PANCS_45
F. Prostate problems (not cancer)		PROST_45
G. Erectile dysfunction (erectile problems)		ERDYS_45
H. High blood pressure or hypertension		HBPHT_45
I. Anemia, low RBC, low hemoglobin		ANEMA_45
J. High cholesterol, high triglycerides, high lipids or too much fat in your blood		HCHOL_45
K. High blood sugar or diabetes		HBSUG_45
L. Arthritis		ARTHR_45
IF YES: Was it: (Read and answer each.) Rheumatoid		RHEUM_45
Osteoarthritis or degenerative		OSTAR_45
Other		OTHAR_45
Specify:		
Don't know		DKWAR_45
M. Angina or chest pain caused by your heart		ANGIN_45
N. Heart attack or myocardial infarction (MI)		HRTAT_45
O. Congestive heart failure or CHF		HRTFA_45
P. Stroke or Cerebrovascular accident (CVA)		STROK_45
Q. Mini-strokes or transient ischemic attacks (TIA)		TIA_45
R. Too fast, too slow, or irregular heart beat		IRHB_45
S. Any blood vessels (arteries) that were blocked or closed — IF NO, SKIP TO Q U		BVES_45
T. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas		OBVES_45
U. A blood clot in your legs		BCLG_45
V. A blood clot in your lungs		BCLN_45
W. Seizure or convulsions		SEZUR_45
X. Osteoporosis (bone thinning)		OSTEO_45
Y. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis		HIPNE_45
Z. Kidney disease/Renal failure		KIDND_45

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

Name of hospital/clinic or doctor

Address

City State

Date of diagnosis

IF ADDITIONAL DOCTOR INFORMATION IS NEEDED, RECORD IN Q30.B ON PAGE 19.

	NO	YES
AA. Liver disease		LIVDS_45
IF YES: Was it: Elevated liver function test/enzyme		LIVDE_45
Other — Specify:		LIVDO_45
Don't know		LIVDK_45

GET MEDICAL RELEASE IF OTHER OR DON'T KNOW

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

Name of hospital/clinic or doctor

Address

City State

Date of diagnosis

BB. Since your last visit [in (MONTH, YEAR)], have you received the injections of the combination vaccine for the prevention of Hepatitis A and B?

- No
- Yes
- Don't Know

HPABSV_45

CC. Since your last visit [in (MONTH, YEAR)], have you received injections or a vaccine for the prevention of Hepatitis A?

- No
- Yes
- Don't Know

HPASV_45

DD. Since your last visit [in (MONTH, YEAR)], have you received injections or a vaccine for the prevention of Hepatitis B?

- No
- Yes
- Don't Know

HPBSV_45

EE. Since your last visit [in (MONTH, YEAR)], have you had any neurological evaluation or a physical examination to look for problems of the nervous system (brain, spinal cord, nerves in hands and feet)? NO YES NRLEX_45

GET MEDICAL RELEASE

IF YES: Was there a diagnosis for your condition? NO YES NRLDX_45

IF YES: What was the diagnosis? NRLCO_45

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

GO TO PAGE 19 TO RECORD ADDITIONAL DOCTORS' NAMES/ADDRESSES.

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FF. Since your last visit [in (MONTH, YEAR)], have you seen a doctor or other medical practitioner for any OTHER NEW conditions or problems in the following areas?

NO YES

a) Eyes — VIDEY_45

IF YES: Was there a diagnosis? — EYDIA_45

What was the diagnosis? — EYCON_45

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) Ears, Nose, Throat, Mouth and Sinuses — VIDEN_45

IF YES: Was there a diagnosis? — ENDIA_45

What was the diagnosis? — ENCON_45

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

c) Heart and Blood Vessels — VIDHT_45

GET MEDICAL RELEASE

IF YES: Was there a diagnosis? — HTDIA_45

What was the diagnosis? — HTCON_45

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) Lungs and Bronchial Tubes — VIDLG_45

IF YES: Was there a diagnosis? — LGDIA_45

What was the diagnosis? — LGCON_45

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) Stomach and Intestines — VIDSI_45

IF YES: Was there a diagnosis? — SIDIA_45

What was the diagnosis? — SICON_45

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) Bones, Joints or Muscles — VIDBJ_45

IF YES: Was there a diagnosis? — BJDIA_45

What was the diagnosis? — BJCON_45

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) Genital, Urinary and Rectal — VIDGU_45

IF YES: Was there a diagnosis? — GUDIA_45

What was the diagnosis? — GUCON_45

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) Skin — VIDSK_45

IF YES: Was there a diagnosis? — SKDIA_45

What was the diagnosis? — SKCON_45

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) Nervous system — VIDNS_45

GET MEDICAL RELEASE

IF YES: Was there a diagnosis? — NSDIA_45

What was the diagnosis? — NSCON_45

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) Psychological — VIDPY_45

IF YES: Was there a diagnosis? — PYDIA_45

What was the diagnosis? — PYCON_45

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

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FF. Continued

NO YES

k) Hormones or Endocrine system VIDHO_45

IF YES: Was there a diagnosis? HODIA_45

What was the diagnosis? HOCON_45

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) Blood VIDBF_45

GET MEDICAL RELEASE

IF YES: Was there a diagnosis? BFDIA_45

What was the diagnosis? BFCON_45

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) Allergy and Immune system other than HIV infection VIDAI_45

IF YES: Was there a diagnosis? AIDIA_45

What was the diagnosis? AICON_45

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) Other VIDO_45

IF YES: Was there a diagnosis? ODIA_45

What was the diagnosis? OCON1_45

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. OCON2_45

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

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

Name of hospital/clinic or doctor

Address

City State

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

1) Facial herpes, cold sores, or fever blisters HERPF_45
2) Sores in genital region HERPG_45
3) Sores in the anal or rectal areas HERPA_45
4) Sores elsewhere on your body HERPE_45

IF "NO" TO ALL FOUR, SKIP TO Q 12

B. Did the first attack of herpes you ever had occur since your last visit [in (MONTH, YEAR)]? HERLV_45

C. Has there been a period since your last visit [in (MONTH, YEAR)] when your (herpes) sores seemed to come more often, get worse or last longer than usual? HERWR_45

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

DISEASE OR CONDITION	HAD DISEASE NO YES
A.1) Syphilis	SYPHA_45
IF "NO," SKIP TO (B)	
A.2) Was this a new infection or was it a continuation or relapse of a previous infection? ◯ New infection ◯ Continued or relapse	SYPHN_45
B) Any form of gonorrhea	GONOR_45
IF "NO" TO (B), SKIP TO (F)	
C) Urethral gonorrhea (clap or drip of the urinary passage)	UGONA_45
D) Oral gonorrhea (of the mouth or throat)	OGONA_45
E) Rectal gonorrhea (of the rectum)	RGONA_45
F) Non-specific or nongonococcal urethriti or chlamydia (that is, a discharge from t penis that's not caused by gonorrhea)	URETC_45
G.1) Genital warts (condylomata acuminata)	WARTG_45
IF "NO," SKIP TO (H)	
G.2) Was this a new infection or was it a continuation or relapse of a previous infection? ◯ New infection ◯ Continued or relapse	WRTGN_45
H.1) Anal warts (condylomata acuminata)	WARTS_45
IF "NO," SKIP TO (I)	
H.2) Was this a new infection or was it a continuation or relapse of a previous infection? ◯ New infection ◯ Continued or relapse	WRTSN_45
I) Any other diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis	PARAA_45

Specify:

SERIAL #

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13.A. Since your last visit [in (MONTH, YEAR)], have you had any of the following problems or symptoms? This includes those due to illnesses or side effects from medications.

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, e, AND f.	a How about (EACH)? Did you have that at any time since your last visit [in (MONTH, YEAR)]? NO YES	b Did that last for two weeks or longer? NO YES	c And do you have that now? NO YES	d Did you experience this symptom due to taking any medication? NO YES DON'T KNOW	e Is this a new condition? IF YES, GO TO COLUMN F NO YES	f In what month and year since your last visit [in (MONTH, YEAR)] 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)]. WHEN BEGAN (Month and Year)	
1) Persistent dizziness for at least 3 consecutive days	DIZZI_45	DIZ2W_45	DIZNO_45	DZMED_45	DIZNC_45	M 97	DIZM_45 DIZY_45 S O N D 03 04 05 06
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	FATIG_45	FAT2W_45	FATIN_45	FTMED_45	FATNC_45	M 97	FATIM_45 FATIY_45 S O N D 03 04 05 06
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	FEVER_45	FEV2W_45	FEVRN_45	FVMED_45	FEVNC_45	M 97	FEVRM_45 FEVRY_45 S O N D 03 04 05 06
4) Persistent, frequent or unusual kinds of head-aches for at least 3 consecutive days	HEADA_45	HED2W_45	HEADN_45	HDMED_45	HEANC_45	M 97	HEADM_45 HEADY_45 S O N D 03 04 05 06
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	RASH_45	RAS2W_45	RASHN_45	RHMED_45	RSHNC_45	M 97	RASHM_45 RASHY_45 S O N D 03 04 05 06
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	GLAND_45	GLN2W_45	GLANN_45	GLMED_45	GLANC_45	M 97	GLANM_45 GLANY_45 S O N D 03 04 05 06
7) Diarrhea for at least 3 consecutive days	DIARR_45	DIA2W_45	DIARN_45	DIMED_45	DIANC_45	M 97	DIARM_45 DIARY_45 S O N D 03 04 05 06
8) Drenching sweats at night on at least 3 occasions	SWEAT_45	SWT2W_45	SWETN_45	SWMED_45	SWENC_45	M 97	SWETM_45 SWETY_45 S O N D 03 04 05 06
9) Nausea, vomiting	VOMIT_45	VOT2W_45	VOTNO_45	VTMED_45	VOTNC_45	M 97	VOTM_45 VOTY_45 S O N D 03 04 05 06
10) Abdominal pain, bloating, cramps	BLOAT_45	ABP2W_45	ABPNO_45	ABMED_45	ABPNC_45	M 97	ABPM_45 ABPY_45 S O N D 03 04 05 06
11) Ascites (fluid buildup in the stomach or abdomen)	ASCIT_45	ASC2W_45	ASCNO_45	ASMED_45	ASCNC_45	M 97	ASCTM_45 ASCTY_45 S O N D 03 04 05 06
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	JDICE_45	JDI2W_45	JDINO_45	JDMED_45	JDINC_45	M 97	JDICM_45 JDICY_45 S O N D 03 04 05 06
13) An unusual bump or skin discoloration that lasted at least two weeks	BRUIS_45		BRUSN_45	BRMED_45	BRUNC_45	M 97	BRUSM_45 BRUSY_45 S O N D 03 04 05 06
14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	WTLOD_45		WTLSN_45	WTMED_45	WTLNC_45	M 97	WTLSM_45 WTLSY_45 S O N D 03 04 05 06
15) Unusual bleeding or bleeding that is difficult to stop	BLEED_45		BLDNO_45	BLMED_45	BLDNC_45	M 97	BLDM_45 BLDY_45 S O N D 03 04 05 06

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13.A. Continued

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, e, AND f.	a How about (EACH)? Did you have that at any time since your last visit [in (MONTH, YEAR)]?	b Did that last for two weeks or longer?	c And do you have that now?	d Did you experience this symptom due to taking any medication?	e Is this a new condition? IF YES, GO TO COLUMN F	f In what month and year since your last visit [in (MONTH, YEAR)] 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 DON'T KNOW	NO YES	WHEN BEGAN (Month and Year)	
16) Muscle pain or weakness	MPAIN_45	MPW2W_45	MPWNO_45	MPMED_45	MPWNC_45	MPWM_45	MPWY_45
17) Joint pain	JOINT_45	JNT2W_45	JNTNO_45	JTMED_45	JNTNC_45	JOINM_45	JOINY_45
18) Painful urination	PURIN_45	URN2W_45	URNNO_45	URMED_45	URNNC_45	URNM_45	URNY_45
19) Blood in urine	BLURN_45	BLU2W_45	BLUNO_45	BUMED_45	BLUNC_45	BLUM_45	BLUY_45
20) Kidney stones	STONE_45		KIDNO_45	KDMED_45	KIDNC_45	KIDM_45	KIDY_45
21) Vivid nightmares or dreams	DREAM_45	NVD2W_45	NVDNO_45	DRMED_45	NVDNC_45	NVDM_45	NVDY_45
22) Insomnia or problems sleeping	INSOM_45	IPS2W_45	IPSNO_45	INMED_45	IPSNC_45	IPSM_45	IPSY_45

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

	If NO, go to next question. If YES, indicate severity. NO YES	Severity (0= None, 1= Mild, 10= Severe)		Did you experience this symptom due to taking any medication? NO YES DON'T KNOW
1. Pain, aching, or burning in your feet or legs?	FEETP_45	PAINR_45	PAINL_45	PLMED_45
2. Pins and needles in your feet or legs?	PINSF_45	PINSR_45	PINSL_45	PIMED_45
3. Numbness (lack of feeling) in your feet or legs?	NUMBF_45	NUMBR_45	NUMBL_45	NBMED_45

Left 0 1 2 3 4 5 6 7 8 9 10

SERIAL #

14. Since your last visit, [in (MONTH, YEAR)], 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 excluding acyclovir.)

- ◯ No
- ◯ Yes → SKIP TO Q 15.A.(1)

MAIDS_45

14.A IF NO: Why did you decide not to take HIV-related medications? READ EACH, MARK ALL THAT APPLY.

- ◯ Not infected with HIV → GO TO (
- ◯ 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 (many times during the day or won't remem)
- ◯ Other reason

Specify:

NMNI_45
NMDS_45
NMNS_45
NMEX_45
NMDW_45
NMSE_45
NMCD_45
NMOR_45

15.A.(1) Since your last visit [in (MONTH, YEAR)], has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs?

RESIT_45

- ◯ No → SKIP TO Q 15.B.(1) IF ON HIV MEDS SINCE LAST VISIT / SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT
- ◯ Yes

(2) What type of test was done?

	NO	YES	DON'T KNOW	
1) Phenotype	◯			PHENO_45
2) Genotype	◯			GENOT_45

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

RSTCH_45

- ◯ No
- ◯ Yes
- ◯ Don't know

SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT

15.B.(1) Since your last visit [in (MONTH, YEAR)], 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)

ML1AD_45

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

READ EACH, MARK ALL THAT APPLY AND THEN SKIP TO Q 15.C

- ◯ Doctor said was not necessary — NMDS1_45
- ◯ Not sick — NMNS1_45
- ◯ Too expensive — NMEX1_45
- ◯ Don't think they work or will help — NMDW1_45
- ◯ Possible side effects — NMSE1_45
- ◯ 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) — NMCD1_45
- ◯ Other reason — NMOR1_45

Specify:

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

STOP

FILL IN THE BUBBLE NEXT TO THE DRUG(S) AND THEN COMPLETE FORM 1 FOR EACH DRUG.

- ◯ abacavir (Ziagen) (218) — ML1A1_45
- ◯ amprenavir (Agenerase) (219) — ML1A2_45
- ◯ atazanavir (Reyataz) (243) — ML1A3_45
- ◯ Combivir (zidovudine + lamivudine) (2 — ML1A4_45
- ◯ d4T (Zerit, Stavudine) (159) — ML1A5_45
- ◯ delavirdine (Rescriptor) (194) — ML1A6_45
- ◯ didanosine (Videx) (147) — ML1A7_45
- ◯ efavirenz (Sustiva) (220) — ML1A8_45
- ◯ emtricitabine (Emtriva, FTC) (239) — ML1A9_45
- ◯ enfuvirtide (Fuzeon, T-20, pentafuside) — ML110_45
- ◯ Epzicom (abacavir, lamivudine) (254) — ML111_45
- ◯ fosamprenavir (Lexiva) (249) — ML112_45
- ◯ indinavir (Crixivan) (212)
- ◯ lamivudine (Epivir, 3TC) (204)
- ◯ lopinavir (Kaletra) (217)
- ◯ nelfinavir (Viracept) (216)
- ◯ nevirapine (Viramune) (191)
- ◯ ritonavir (Norvir) (211)
- ◯ saquinavir (Invirase, Fortovase) (210)
- ◯ tenofovir (Viread) (234)
- ◯ tipranavir (238)
- ◯ Trizivir (abacavir + lamivudine + zidovudine) (240)
- ◯ Truvada (emtricitabine + tenofovir) (253)
- ◯ zidovudine (Retrovir, AZT) (092)
- ◯ Other anti-retroviral from Drug List 1 (Report Acyclovir in Q 16.)

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 [in (MONTH, YEAR)], 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

MDRUG_45

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

MISTI_45

Did your physician prescribe or agree to any of these?

PDRUG_45 ◯ No ◯ Yes

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

DDRUG_45

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

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15.C.(1) Since your last visit [in (MONTH, YEAR)], 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

ML2AD_45

STOP

(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. COMPLETE DRUG FORM 2 FOR EACH DRUG.

- ◯ atovaquone (Mepron, BW566C80) **(190)**
- ◯ azithromycin (Zithromax) **(152)**
- ◯ Bactrim (Septra, TMP/SMX) **(112)**
- ◯ ciprofloxacin (Cipro) **(153)**
- ◯ clarithromycin (Biaxin) **(184)**
- ◯ co-enzyme Q **(196)**
- ◯ colony stimulating factor (G-CSF, Neupogen) **(157)**
- ◯ dapsone **(113)**
- ◯ DHEA (dihydroepiandrostenedione) **(161)**
- ◯ erythropoietin (Epogen, Procrit, Aranesp) **(117)**
- ◯ ethambutol (Myambutol) **(137)**
- ◯ fluconazole (Diflucan) **(116)**
- ◯ foscarnet (foscavir) **(091)**
- ◯ ganciclovir (Cytovene, DHPG, valcyte, valganciclovir) **(125)**
- ◯ interleukin 2 (IL-2) **(096)**
- ◯ Marinol (dronabinol) **(547)**
- ◯ Megace (megestrol acetate) **(123)**
- ◯ NAC (N-acetyl cysteine) **(188)**
- ◯ Nandrolone (deca-durabolin) **(232)**
- ◯ Oxandrin (oxandrolone) **(228)**
- ◯ rifabutin (Mycobutin, Ansamycin) **(093)**
- ◯ Serostim (human growth hormone) **(245)**
- ◯ testosterone (Androgel, Androderm, Delatestryl, Striant, Testoderm, Virilon) **(236)**
- ◯ Other from Drug List 2 **(Report Acyclovir in Q 16.)**

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

ML2A1_45
ML2A2_45
ML2A3_45
ML2A4_45
ML2A5_45
ML2A6_45
ML2A7_45
ML2A8_45
ML2A9_45
ML210_45
ML211_45
ML212_45

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15.D.(1) Since your last visit [in (MONTH, YEAR)], 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

OMDAD_45

(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

OMDA1_45
OMDA2_45
OMDA3_45
OMDA4_45
OMDA5_45
OMDA6_45

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16. Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include prescribed medications, over the counter medications, and other medications you took on your own since your last visit [in (MONTH, YEAR)].

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a) IF "NO" TO a GO TO NEXT ITEM		a How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]? NO YES	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?	c Have you taken/used any in the past 5 days (FOR ASPIRIN:in the last week)? NO YES
1) Steroids that you took by mouth or were injected		STRAV_45	Name:	STRA5_45
2) Thyroid hormone or thyroid medication		THYRV_45	Name:	THYR5_45
3) Other hormones such as anabolic steroids		HORMV_45	Name:	HORM5_45
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug		ANTBV_45	Name:	ANTB5_45
5) Medication taken by mouth for fungal infection		FGMDV_45	Name:	FGMD5_45
6) Medication taken by mouth for worms or parasites		WRMDV_45	Name:	WRMD5_45
7) Tranquilizers or sleeping pills		TRNQV_45	Name:	TRNQ5_45
8) Antidepressants or mood elevators		MOODV_45	Name:	MOOD5_45
9) Lithium		LITHV_45	Name:	LITH5_45
10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it: Everyday? ◯ No ◯ Yes Only when you had active lesions or had an outbreak? ◯ No ◯ Yes		ACYCV_45 CHACY_45 EPACY_45	Name:	ACYC5_45
11) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction		VIAGR_45	Name:	VIAG5_45
12) Aspirin taken three days or more on a weekly basis		ASPRN_45	Name:	ASPR7_45
13) Cholesterol, triglycerides, lipid or any blood fat lowering medications	a. 0 100 200 300 400 500 600 700 800 900 / 0 10 … 80 90 / 0 1 … 8 9	CHDG1_45 CHOL1_45	Name:	CHL15_45
	b. 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	CHDG2_45 CHOL2_45	Name:	CHL25_45
	c. 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	CHDG3_45 CHOL3_45	Name:	CHL35_45
14) Hypertension medications	a. 0 1000 … 8000 9000 / 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	HTDG1_45 HYPT1_45	Name:	HYP15_45
	b. 0 1000 … 8000 9000 / 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	HTDG2_45 HYPT2_45	Name:	HYP25_45
	c. 0 1000 … 8000 9000 / 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	HTDG3_45 HYPT3_45	Name:	HYP35_45
	d. 0 1000 … 8000 9000 / 0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9	HTDG4_45 HYPT4_45	Name:	HYP45_45
	e. 0 1000 … 8000 9000 / 0 100 … 800 900 / 0 10 … 80 90 / 0 1 2 3 4 5 6 7 8 9	HTDG5_45 HYPT5_45	Name:	HYP55_45

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16. Continued	ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a) IF "NO" TO a GO TO NEXT ITEM	a How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]? NO YES	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?	c Have you taken/used any in the past 5 days (FOR ASPIRIN:in the last week)? NO YES
15) Medications used for diabetes a.	DIAT1_45	DIAB1_45	Name:	DIA15_45
b.	DIAT2_45	DIAB2_45	Name:	DIA25_45
c.	DIAT3_45	DIAB3_45	Name:	DIA35_45
16) Hepatitis medications a.	HEPT1_45	HEPD1_45	Name:	HEP15_45
b.	HEPT2_45	HEPD2_45	Name:	HEP25_45
17) Other a.	DRUG1_45	ODRG1_45	Name: Used for:	ODG15_45
b.	DRUG2_45	ODRG2_45	Name: Used for:	ODG25_45
c.	DRUG3_45	ODRG3_45	Name: Used for:	ODG35_45
d.	DRUG4_45	ODRG4_45	Name: Used for:	ODG45_45
e.	DRUG5_45	ODRG5_45	Name: Used for:	ODG55_45
f.	DRUG6_45	ODRG6_45	Name: Used for:	ODG65_45
g.	DRUG7_45	ODRG7_45	Name: Used for:	ODG75_45
h.	DRUG8_45	ODRG8_45	Name: Used for:	ODG85_45

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

◯ No → SKIP TO Q 18 ◯ Yes HIVAC_45

B. Do you know the name of the trial?

◯ No ◯ Yes → Specify: HVACC_45 HVACN_45

	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

Date started trial

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

18.A. Since your last visit [in (MONTH, YEAR)], have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

◯ No → SKIP TO Q 18.A9 MEDCV_45

◯ Yes - did you have

	NO	YES	
1) Coverage by an HMO	◯	◯	HMOC_45
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)	◯	◯	GPIC_45
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)	◯	◯	IPIC_45
4) Medicaid, Medi-Cal, or Medical Assistance	◯	◯	MCAID_45
5) Medicare (for people over 65 or permanently disabled)	◯	◯	MCARE_45
6) Health care benefits for The Armed Forces or Veteran's Administration	◯	◯	VABEN_45
7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans	◯	◯	CHAMP_45
8) Other	◯	◯	OTHER_45
9) ADAP (AIDS Drug Assistance Program)	◯	◯	ADAP_45

Specify:

B. Do you have insurance coverage that pays for any of your medications?

	NO	YES	
	◯	◯	INSDG_45

IF NO TO Q 18.A AND NO TO Q 18.B, THEN SKIP TO Q 22

19. Are you currently insured? INCUR_45

◯ No

◯ Yes

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20. Since your last visit [in (MONTH, YEAR)], have you lost health insurance coverage or been denied health insurance for poor health?

- ◯ No → SKIP TO Q 22
- ◯ Yes

PHINS_45

21. What condition caused you to lose or be denied health insurance?

- ◯ HIV infection
- ◯ Other

PHCON_45

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

- ◯ No
- ◯ Yes

DINS_45

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

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

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

UCMED_45

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24. Since your last visit [in (MONTH, YEAR)], 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 [in (MONTH, YEAR)]? (NO / YES)	b. How many times? (99 = 99 or more)
1) HMO	HMOOV_45	HMONU_45
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care	DOCOV_45	DOCNU_45
3) Any other clinic	CLOV_45	CLNUM_45
4) Emergency room	EROV_45	ERNUM_45
5) Other outpatient service (Specify below)	OPOV_45	OPNUM_45

Specify:

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

SERVICE	a Have you used (EACH) since your last visit [in (MONTH, YEAR)]?	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	DENTV_45 DHNUM_45 70 80 90 7 8 9
2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)	◯ NO GO TO NEXT ROW ◯ YES	USEMH_45 MHNUM_45 70 80 90 7 8 9
3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist, masseuse)	◯ NO GO TO NEXT ROW ◯ YES	USEAO_45 AONUM_45 70 80 90 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	USEHC_45 HCNUM_45 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

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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, YEAR)]. [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN $1]

$ ____,___ PMPAY_45

0 10M 20M 30M 40M 50M 60M 70M 80M 90M
0 1M 8M 9M
0 100 800 900
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, YEAR)] 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 NSMDP_45
- Yes

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

1) Medical care NSMED_45
- No → SKIP TO (2)
- Yes → Why did you not seek medical care?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons NSEEK_45
- Other non-financial reasons NMOTH_45

Specify:

2) Dental care NSDEN_45
- No → SKIP TO (3)
- Yes → Why did you not seek dental care?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons NDFIN_45
- Other non-financial reasons NDOTH_45

Specify:

3) Prescription Medications NOPRE_45
- No → SKIP TO Q 28
- Yes → Why did you not obtain prescription medications?

[READ EACH AND MARK ALL THAT APPLY]
- Financial reasons NPFIN_45
- Other non-financial reasons NPOTH_45

Specify:

28. Was there a time since your last visit [in (MONTH, YEAR)] when you were refused care from a doctor or other medical provider?
- No REMED_45
- Yes

29. Was there a time since your last visit [in (MONTH, YEAR)] when you were refused dental care?
- No REDEN_45
- Yes

30.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 31
- Yes OTINF_45

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

31. ACASI interview?
- No ACASI_45
- Yes

32. Telephone interview?
- No PHINT_45
- Yes

33. Home visit?
- No HVINT_45
- Yes

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34.

35.

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	

S4TEH_45
S4TEM_45
S4TEZ_45

36.

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

INTVN_45

ACASI begins here.

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

INCOM_45

- ◯ 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

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

FNDIF_45

- ◯ No → SKIP TO Q 39
- ◯ Yes

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

FNDFL_45

- ◯ Less
- ◯ Same
- ◯ Greater

39. Since your last visit [in (MONTH, YEAR)], has your employment status changed for any reason related to HIV disease?

JOBHI_45

- ◯ No → SKIP TO Q 40
- ◯ Yes

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

	NO YES
1) Became too sick to work	TSICK_45
2) HIV status became known to employer	STKNE_45
3) HIV status became known to coworkers	STKNC_45
4) Early retirement	RETEY_45
5) Changed job as a personal decision	JOBPE_45
6) To receive better health insurance benefits	JOBHE_45
7) To receive better disability benefits	DISAB_45
8) Other	JOBOT_45

Specify:

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SERIAL #

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

40. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes? **ESMOK_45**

- ◯ No → SKIP TO Q 41
- ◯ Yes

B. Do you smoke cigarettes now? (As of one month ago?) **SMOKN_45**

- ◯ No → SKIP TO Q 41
- ◯ Yes
- ◯ Occasionally (less than one cigarette per day) → SKIP TO Q 41

C. How many packs do you usually smoke per day? **PACKS_45**

- ◯ 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

41. The next set of questions are about alcoholic beverages. They may seem similar, but they are asked in a slightly different way.

Please answer each of the following questions for the past 6 months.

A. How often have you had drinks containing alcohol? **FADRNK_45**

- ◯ Never → STOP – SKIP TO Q 41K
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

B. During the past 6 months, how many drinks containing alcohol have you had on a typical day when you are drinking? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.) **NADRNK_45**

- ◯ 1 or 2
- ◯ 3 or 4
- ◯ 5 or 6
- ◯ 7 to 9
- ◯ 10 or more
- ◯ None

C. During the past 6 months, how often have you had six or more drinks on one occasion? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.) **DRNK6_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

D. How often during the past 6 months have you found that you were not able to stop drinking once you started? **NSDRK_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

E. How often during the past 6 months have you failed to do what was normally expected from you because of drinking? **FLDRK_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

F. How often during the past 6 months have you needed a first drink in the morning to get yourself going after a heavy drinking session? **MODRNK_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost daily

G. How often during the past 6 months have you had a feeling of guilt or remorse after drinking? **GDRNK_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost d

H. How often during the past 6 months have you been unable to remember what happened the night before because you had been drinking? **RDRNK_45**

- ◯ Never
- ◯ Less than monthly
- ◯ Monthly
- ◯ Weekly
- ◯ Daily or almost (

I. Have you or someone else been injured as a result of your drinking? **HDRNK_45**

- ◯ No
- ◯ Yes, but not in the past 6 months
- ◯ Yes, during the past 6 months

J. Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down? **CDRNK_45**

- ◯ No
- ◯ Yes, but not in the past 6 months
- ◯ Yes, during the past 6 months

K. Since your last visit [in (MONTH, YEAR)], have you been in an alcohol treatment program, including inpatient and/or outpatient detox, alcoholics anonymous, and/or any other program? **ALTSV_45**

- ◯ No
- ◯ Yes

READ DEFINITION OF SEXUAL ACTIVITY:

> **SEXUAL ACTIVITY** includes oral sex, anal/butt sex, vaginal sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

42. Have you engaged in any sort of sexual activities involving another person since your last visit [in (MONTH, YEAR)]? **SEXAV_45**

- ◯ No → SKIP TO Q 49
- ◯ Yes

43. Have you had any sexual activity with a woman since your last visit [in (MONTH, YEAR)]? **SEXVF_45**

- ◯ No → SKIP TO Q 46
- ◯ Yes

GO TO QUESTION 44 ON NEXT PAGE.

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44. Now lets talk about how many different women you have had sexual activity with since your last visit [in (MONTH, YEAR)].

A. How many different women (if any) have you had sexual intercourse with since your last visit [in (MONTH, YEAR)]? Here we define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus/butt, with or without ejaculation.

	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

NSEXF_45

B. With how many (other) women have you had sexual activity that did not include intercourse since your last visit [in (MONTH, YEAR)]?

	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

NSXAF_45

The next questions are about different kinds of sexual activity men have with women.

IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 45.10

45. **IF ONLY ONE PARTNER: USE COLUMN a.**

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).	NO YES OINF1_45	0 100 200 300 400 500 600 700 800 900 / 0 10 … 80 90 / 0 1 … 8 9 NOINF_45
IF MULTIPLE PARTNERS: 2) With how many of those women did you use a condom every time for oral sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time you had oral sex even if it broke, tore, or slipped?	COIF1_45	0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9 NCOIF_45
IF MULTIPLE PARTNERS: 3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?	OEJF1_45	0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9 NOEJF_45
4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).	VINF1_45	0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9 NVINF_45
IF MULTIPLE PARTNERS: 5) With how many of those women did you use a condom every time for vaginal sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?	CVIF1_45	0 100 … 800 900 / 0 10 … 80 90 / 0 1 … 8 9 NCVIF_45
IF MULTIPLE PARTNERS: 6) With how many women did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?	VEJF1_45 NO YES	0 100 … 800 900 / 0 10 … 80 90 / 0 1 2 3 4 5 6 7 8 9 NVEJF_45

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45. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a. Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b. How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).	NO YES AINF1_45	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 NAINF_45
IF MULTIPLE PARTNERS: 8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?	CAIF1_45	0 100 … 900 / 0 10 … 80 90 / 0 1 … 8 9 NCAIF_45
IF MULTIPLE PARTNERS: 9) With how many women did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?	AEJF1_45	0 100 … 900 / 0 10 … 80 90 / 0 1 … 8 9 NAEJF_45
10) You used your tongue to touch or lick her anus/butt ("rimming").	RIMF1_45	0 100 … 900 / 0 10 … 80 90 / 0 1 … 8 9 NRIMF_45
11) You used your tongue to touch or lick her genitals (vagina, clitoris).	LICF1_45	0 100 … 900 / 0 10 … 80 90 / 0 1 2 3 4 5 6 7 8 9 NLICF_45

46. Have you had any sort of sexual activity with a man since your last visit [in (MONTH, YEAR)]?

- ○ No → SKIP TO Q 49
- ○ Yes

SEXVM_45

47. Now lets talk about how many different men you have had sexual activity with since your last visit [in (MONTH, YEAR)].

A. How many different men (if any) have you had sexual intercourse with since your last visit [in (MONTH, YEAR)]? Here we define sexual intercourse as follows: you put your penis in your partner's mouth or anus/butt—or your partner put his penis in your mouth or anus/butt, with or without ejaculation.

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

NSEXM_45

B. With how many (other) men have you had sexual activity that did not include intercourse since your last visit [in (MONTH, YEAR)]?

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

NNSXM_45

3/8" spine perf

The next questions are about different kinds of sexual activity some men engage in with other men.
IF NO INTERCOURSE WITH MEN, SKIP TO Q 48.13

48. IF ONLY ONE PARTNER: USE COLUMN a.
IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a. Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b. How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (4).	NO YES ORIN1_45	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 NOINM_45
IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom every time, even if it broke, tore, or slipped?	COIN1_45	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 NCOIM_45
IF MULTIPLE PARTNERS: 3) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?	OEJM1_45	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 NOEJM_45
4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).	ANIN1_45	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 NAINM_45
IF MULTIPLE PARTNERS: 5b.) Thinking of the times you put your penis in their anus/butt, with how many men did you use a condom every time, even if it broke, tore, or slipped? If any unprotected anal sex (Q5b < Q4) then read: For those men with whom you did not use a condom, 5b.1) Were any of these men HIV positive? 5b.2) Were any of these men HIV negative? If 5b.1 or 5b.2 = Don't Know/Not Sure, skip to 6b. 5b.3) Were you unsure of the HIV status of any of these men? IF ONE PARTNER: 5a.) Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped? If 5a = No, 5a.1) What was the HIV status of your partner when you did not use a condom?	NO YES CAIN1_45 NEG. POS. DON'T KNOW/ NOT SURE HIVSTAT1_45	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 NCAIM_45 NO YES DON'T KNOW/ NOT SURE 5b.1) 5b.2) 5b.3) HPAIM_45 HNAIM_45 HUAIM_45
IF MULTIPLE PARTNERS: 6b.) With how many men did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)? IF ONE PARTNER: 6a.) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?	AEJM1_45 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 NAEJM_45

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48. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).	NO YES ORRC1_45	0 100 200 300 400 500 600 700 800 900 / 0 10 ... 90 / 0 1 ... 9 NORCM_45
IF MULTIPLE PARTNERS: 8) Thinking of the times when a man put his penis in your mouth, with how many men was a condom used every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times when he put his penis in your mouth, was a condom used every time, even if it broke, tore, or slipped?	CORR1_45	0 100 ... 900 / 0 10 ... 90 / 0 1 ... 9 NCORM_45
IF MULTIPLE PARTNERS: 9) With how many men did ejaculate/cum go into your mouth when they did not use a condom (or when a condom failed)? IF ONE PARTNER: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?	OREM1_45 NO YES	0 100 ... 900 / 0 10 ... 90 / 0 1 ... 9 NOREM_45
10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).	NO YES ANRC1_45	0 100 ... 900 / 0 10 ... 90 / 0 1 2 3 4 5 6 7 8 9 NARIM_45
IF MULTIPLE PARTNERS: 11b.) Thinking of the times when a man put his penis in your anus/butt, with how many men was a condom used every time, even if it broke, tore, or slipped? If any unprotected anal sex (Q11b < Q10) then read: Of the men who did not use a condom, 11b.1) Were any of these men HIV positive? 11b.2) Were any of these men HIV negative? If 11b.1 or 11b.2 = Don't Know/Not Sure, skip to 12b. 11b.3) Were you unsure of the HIV status of any of these men? IF ONE PARTNER: 11a.) Thinking of the times when he put his penis in your anus/butt, was a condom used every time, even if it broke, tore, or slipped? If 11a = No, 11a.1) What was the HIV status of your partner when he did not use a condom?	CANR1_45 NO YES; HIVSTAT2_45 NEG. POS. DON'T KNOW/ NOT SURE	0 100 ... 900 / 0 10 ... 80 90 / 0 1 2 3 4 5 6 7 8 9 NCARM_45; 11b.1) NO YES DON'T KNOW/ NOT SURE HPARM_45; 11b.2) HNARM_45; 11b.3) HUARM_45
IF MULTIPLE PARTNERS: 12b.) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)? IF ONE PARTNER: 12a.) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?	AREM1_45 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 NAREM_45

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48. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a. Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b. How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
13) You used your tongue to touch or lick his anus/butt ("rimming").	NO YES RIMI1_45	0 100 200 300 400 500 600 700 800 900 / 0 NRMIM_45 0 80 90 / 0 8 9

If the participant had a total of only one sex partner (male or female) since the last visit (Male Q 47.A + 47.B = 1, or Female Q 44.A + 44.B = 1), ask question 48.14. If the participant had more than one sex partner since the last visit, SKIP Q 48.14 and continue with Q 48.15.

48.14) You said you had (intercourse or sexual activity) with only one person since your last visit [in (MONTH, YEAR)]. How would you describe this individual?

- ◯ Main partner or someone you have a longstanding relationship with, live with, or partner with
- ◯ Casual partner, one-time partner, or person with whom you have not developed a longstanding, close relationship with

SKIP TO Q 48.18

PART1_45

48.15) You mentioned that you had sex with more than one person since your last visit [in (MONTH, YEAR)]. Would you consider only one of these persons to be a main partner or someone you have a longstanding relationship with, live with, or partner with?

- ◯ No → **SKIP TO Q 48.18**
- ◯ Yes

PARTM_45

A. Was your main partner a man or a woman?

- ◯ Man
- ◯ Woman

MPGEN_45

48.16) Did you have unprotected intercourse (anal or vaginal) with your main partner in the last 6 months?

- ◯ No → **SKIP TO Q 48.18**
- ◯ Yes

MPANA_45

48.17) What is the HIV status of your main partner?

- ◯ Negative
- ◯ Positive
- ◯ I don't know

MPHIV_45

48.18) Have you met any new partners to engage in any type of sexual activity since your last visit [in (MONTH, YEAR)]?

- ◯ No → **SKIP TO Q 49**
- ◯ Yes

METNW_45

48.19) Some men meet new sexual partners through different sources and in different settings. Since your last MACS visit [in (MONTH, YEAR)], have you met one or more new male sexual partners in any of the following settings?

	NO YES
a) on the internet	METIN_45
b) at a party (including a circuit party)	METPY_45
c) through an advertisement in a newspaper or other newsletter	METAD_45
d) at a bar	METBAR_45
e) at a bath house	METBH_45
f) in a park or other outdoor public place	METOP_45
g) in a bathroom, bookstore, or other indoor public place	METIP_45
h) at a place where drugs were used or exchanged	METDR_45
i) other place not listed above	METOT_45

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49. 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 last visit [in (MONTH, YEAR)]?

	a How about (EACH) Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	b How often did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]?			
		DAILY	WEEKLY	MONTHLY	LESS OFTEN
	NO YES				
Pot, Marijuana or Hash	HASHV_45	○	HASHF_45		○
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	POPPV_45	○	POPPF_45		○
Crack or cocaine that you smoke	CRACV_45	○	CRACF_45		○
Other forms of cocaine	OCOKV_45	○	OCOKF_45		○
Speed, Meth or Ice	UPPRV_45	○	UPPRF_45		○
Heroin	HEROV_45	○	HEROF_45		○
Speedball (heroin and cocaine together)	SPEBV_45	○	SPEBF_45		○
Ecstasy, XTC, X or MDMA	MDAV_45	○	MDAF_45		○
Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction (Show list of performance enhancing drugs to prompt and assist with recall.)	SEXPD_45	○	SEXPO_45		○
Other kinds of street/club drugs	STMDV_45				
Specify: ○ 0 1 2 3 4 5 6 7	STMD1_45	○	ST1DF_45		○
Specify: ○ 0 1 2 3 4 5 6 7	STMD2_45	○	ST2DF_45		○
Specify: ○ 0 1 2 3 4 5 6 7	STMD3_45	○	ST3DF_45		○
Specify: ○ 0 1 2 3 4 5 6 7	STMD4_45	○	ST4DF_45		○
Specify: ○ 0 1 2 3 4 5 6 7	STMD5_45	○	ST5DF_45		○
Specify: ○ 0 1 2 3 4 5 6 7	STMD6_45	○	ST6DF_45		○

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

- ◯ No → SKIP TO Q 56
- ◯ Yes

RCDRG_45

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

- ◯ No
- ◯ Yes

RCDSG_45

C. Do you currently inject drugs?

- ◯ No
- ◯ Yes

RCDNO_45

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

Speedball (cocaine and heroin together)

TINSB_45

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

Cocaine by itself

TINCO_45

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

Heroin by itself

TINHO_45

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

Speed by itself

TINSO_45

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

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

- ◯ No → SKIP TO Q 53
- ◯ Yes

SHRNW_45

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

TSHNW_45

	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?

SHWNP_45

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

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

- ◯ No → SKIP TO Q 54
- ◯ Yes

SH2OR_45

B. How many times?

TSH2O_45

	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?

DPH2O_45

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

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

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

FBLEA_45

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

- ◯ No → SKIP TO Q 56
- ◯ Yes

PNEP_45

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

HONEP_45

C. Do you have another source of clean needles?

- ◯ No
- ◯ Yes

OSCLN_45

56. Since your last visit [in (MONTH, YEAR)], 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

DRGTP_45

Interviewer Instructions:

Thank the participant.

Record the time ended on page 20.

3/8" spine perf

SERIAL #