WOMENS INTERAGENCY HIV STUDY AUTOIMMUNE DISEASE FORM (ADF)

SECTION A. GENERAL INFORMATION

A1.	PARTICIPANT ID: ENTER NUMBER HERE ONLY IF ID LABEL IS NOT AVAILABLE	- - -
A2.	VISIT #:	
A3.	VERSION DATE:	10/01/12
A4.	DATE OF INTERVIEW:	/ / M D Y
A5.	INTERVIEWER'S INITIALS:	
A6.	TIME MODULE STARTED:	: AM 1 PM 2
B1.	Have you ever been diagnosed with Lupus, Sjogren's syndron Hashimoto's thyroiditis or low thyroid hormone? YES	ne, Multiple Sclerosis (MS), Graves disease or high thyroid hormone, or

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B2.	Since your (MONTH) study visit, has a health care provider given you a new diagnosis of Lupus?
	YES1 (b)
	NO2
a.	Have you ever had a health care provider tell you that you have Lupus?
	YES
b.	When were you first told you had Lupus? _ / / M D Y
c.	Have you ever taken any medications or other treatments for Lupus? YES
	NO

	ARTICIPANT RESPONSE CARD C1 which drugs or treatments you have tak		i. START DATE (MM/DD/YY)	ii. STOP DATE (MM/DD/YY)
DRUG1	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	//// (f)	
	Lupus1	e. When did you last start and stop taking this drug (treatment)?	////	/ / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	c. Are you currently taking this drug	g. When?	//	_ / / (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	NO2 (e)	i. When?		

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HAND P	ARTICIPANT RESPONSE CARD C1	•	i. START DATE	ii. STOP DATE
Specify w	hich drugs or treatments you have tak	en for treatment of Lupus:	(MM/DD/YY)	(MM/DD/YY)
DRUG2	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	/// (f)	
	Lupus1	e. When did you last start and stop taking this drug (treatment)?	/ //	
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
	c. Are you currently taking this drug?	g. When?		_/ (h)
	YES1 NO2 (e)	h. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
		i. When?	////	////
DRUG3	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	_ / (f)	
	Lupus1	e. When did you last start and stop taking this drug (treatment)?	/ //	
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (B3)		
	c. Are you currently taking this drug	g. When?		_ / (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (B3)		
	NO2 (e)	i. When?		

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В3.	Since your (MONTH) study visit, has a health care provider given you a new diagnosis of Sjogren's syndrome?
	YES1 (b)
	NO2
a.	Have you ever had a health care provider tell you that you have Sjogren's syndrome?
	YES1
	NO
b.	When were you first told you had Sjogren's syndrome?
	$f M \qquad f D \qquad f Y$
c.	Have you ever taken any medications or other treatments for Sjogren's syndrome?
	YES1
	NO

	ARTICIPANT RESPONSE CARD C2		i. START DATE	ii. STOP DATE
Specify w	vhich drugs or treatments you have tak	en for treatment of Sjogren's syndrome:	(MM/DD/YY)	(MM/DD/YY)
DRUG1	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	//(f)	
	Sjogren's2	e. When did you last start and stop taking this drug (treatment)?	////	_ / / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	c. Are you currently taking this drug	g. When?	/ /	////(h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	NO2 (e)	i. When?	//	

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HAND PARTICIPANT RESPONSE CARD C2.		i. START DATE	ii. STOP DATE
Specify which drugs or treatments you have taken for	or treatment of Sjogren's syndrome:	(MM/DD/YY)	(MM/DD/YY)
d V	When did you start taking this drug (treatment)		

Specify w	hich drugs or treatments you have tak	ten for treatment of Sjogren's syndrome:	(MM/DD/YY)	(MM/DD/YY)
DRUG2	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	_ / (f)	
	Sjogren's2	e. When did you last start and stop taking this drug (treatment)?	////	/ _ (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO		
	c. Are you currently taking this drug	g. When?	_ _ / _ / _	_/ (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
	NO2 (e)	i. When?	_ / /	_/
DRUG3	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	_ / (f)	
	Sjogren's2	e. When did you last start and stop taking this drug (treatment)?	////	_ / / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (B4)		
	c. Are you currently taking this drug	g. When?	_ _ / _ / _	_/ (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (B4)		
	NO2 (e)	i. When?		

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B4.	Since your (MONTH) study visit, has a health care provider given you a new diagnosis of Multiple Sclerosis (MS)?
	YES1 (b)
	NO2
a.	Have you ever had a health care provider tell you that you have MS?
	YES
	110
b.	When were you first told you had MS? _ / _ / _ M D Y
c.	Have you ever taken, any medications or other treatments for MS?
	YES

	ARTICIPANT RESPONSE CARD C3 which drugs or treatments you have tak		i. START DATE (MM/DD/YY)	ii. STOP DATE (MM/DD/YY)
DRUG1	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	_ / / _ (f)	
	MS3	e. When did you last start and stop taking this drug (treatment)?	////	/ / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	c. Are you currently taking this drug	g. When?		//(h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO		
	NO2 (e)	i. When?	///	_ _ / _ / _

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HAND PARTICIPANT RESPONSE CARD C3.			i. START DATE	ii. STOP DATE
Specify which drugs or treatments you have taken for treatment of MS:			(MM/DD/YY)	(MM/DD/YY)
DRUG2	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	////(f)	
	MS3	e. When did you last start and stop taking this drug (treatment)?	/ //	_ _ / _ / _ (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
	c. Are you currently taking this drug	g. When?	//	_ _ / _ (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
	NO2 (e)	i. When?	////	//
DRUG3	a. DISEASE: MS3 b. SPECIFY DRUG/TREATMENT: c. Are you currently taking this drug (treatment)? YES1 NO2 (e)	d. When did you start taking this drug (treatment) most recently?	//// (f)	
		e. When did you last start and stop taking this drug (treatment)?	////	_ / (f)
		f. Did you start and stop taking it before that? YES1 NO2 (B5)		
		g. When?	_ _ / _ / _	_ / (h)
		h. Did you start and stop taking it before that? YES1 NO2 (B5)		
		i. When?		

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B5.	Since your (MONTH) study visit, has a health care provider given you a new diagnosis of Graves disease or high thyroid hormone?
	YES 1 (b)
	NO2
a.	Have you ever had a health care provider tell you that you have Graves disease or high thyroid hormone? YES
b.	When were you first told you had high thyroid hormone? _/ / M D Y
c.	Have you ever taken any medications or other treatments for high thyroid hormone? YES

HAND PARTICIPANT RESPONSE CARD C4.			i. START DATE	ii. STOP DATE
Specify which drugs or treatments you have taken for treatment of high thyroid hormone:			(MM/DD/YY)	(MM/DD/YY)
DRUG1	a. DISEASE: high thyroid4	d. When did you start taking this drug (treatment) most recently?	/ / (f)	
		e. When did you last start and stop taking this drug (treatment)?	//	//(f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	c. Are you currently taking this drug	g. When?	//	_ _ / _ / _ (h)
(treat:	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
	NO2 (e)	i. When?		

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HA	ND P	ARTICIPANT RESPONSE CARD C4.	•	i. START DATE
Specify which drugs or treatments you have taken for treatment of high thyroid hormone:			(MM/DD/YY)	
	·		d. When did you start taking this drug (treatment)	

HAND PARTICIPANT RESPONSE CARD C4.			i. START DATE	ii. STOP DATE
Specify which drugs or treatments you have taken for treatment of high thyroid hormone:			(MM/DD/YY)	(MM/DD/YY)
DRUG2	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	/	
	High thyroid4	e. When did you last start and stop taking this drug (treatment)?	////	_ / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
	c. Are you currently taking this drug	g. When?	_ _ / _ / _	_ / (h)
	(treatment)? YES1	h. Did you start and stop taking it before that? YES1 NO		
	NO2 (e)	i. When?	////	/
High th	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	/	
	High thyroid4 b. SPECIFY DRUG/TREATMENT:	e. When did you last start and stop taking this drug (treatment)?	////	_ / (f)
		f. Did you start and stop taking it before that? YES1 NO2 (B6)		
	c. Are you currently taking this drug (treatment? YES1	g. When?		_/ (h)
		h. Did you start and stop taking it before that? YES1 NO2 (B6)		
	NO2 (e)	i. When?	_ _ / _ / _	

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B6.	Since your (MONTH) study visit, ha hormone?	s a health care provider given you a new diagnosis of F	Hashimoto's thyroiditis or lo	w thyroid
	YES	1 (b)		
	NO	2		
	YES	w thyroid hormone? Wider tell you that you have Hashimoto's thyroiditis or 1	low thyroid hormone?	
,	YES	s or other treatments for low thyroid hormone?		
STA	ART ADFs1			
D PA	ARTICIPANT RESPONSE CARD C5	•	i. START DATE	ii. STOP DATE
ify w	hich drugs or treatments you have tak	en for treatment of low thyroid hormone:	(MM/DD/YY)	(MM/DD/YY)
G1	a. DISEASE:	d. When did you start taking this drug (treatment) most recently?	/// (f)	

HAND PARTICIPANT RESPONSE CARD C5.			i. START DATE	ii. STOP DATE
Specify which drugs or treatments you have taken for treatment of low thyroid hormone:			(MM/DD/YY)	(MM/DD/YY)
DRUG1	Low thyroid5	d. When did you start taking this drug (treatment) most recently?	_ / (f)	
		e. When did you last start and stop taking this drug (treatment)?	/ /	_/ (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
C	c. Are you currently taking this drug (treatment)? YES1 NO2 (e)	g. When?		_ / (h)
		h. Did you start and stop taking it before that? YES1 NO2 (DRUG2)		
		i. When?		///

HAND PARTICIPANT RESPONSE CARD C5. Specify which drugs or treatments you have taken for treatment of low thyroid hormone:			i. START DATE (MM/DD/YY)	ii. STOP DATE (MM/DD/YY)
DRUG2	a. DISEASE: Low thryoid5	d. When did you start taking this drug (treatment) most recently?	_ / (f)	
		e. When did you last start and stop taking this drug (treatment)?	////	/ / (f)
	b. SPECIFY DRUG/TREATMENT:	f. Did you start and stop taking it before that? YES1 NO		
	c. Are you currently taking this drug (treatment)? YES1 NO2 (e)	g. When?	//	_ _ / _ (h)
		h. Did you start and stop taking it before that? YES1 NO2 (DRUG3)		
		i. When?	_ _ / _ / _	
DRUG3	a. DISEASE: Low thyroid5 b. SPECIFY DRUG/TREATMENT:	d. When did you start taking this drug (treatment) most recently?	/ / (f)	
		e. When did you last start and stop taking this drug (treatment)?	//	_ / (f)
		f. Did you start and stop taking it before that? YES1 NO		
	c. Are you currently taking this drug (treatment)? YES1 NO2 (e)	g. When?		_ / (h)
		h. Did you start and stop taking it before that? YES1 NO2 (B7)		
		i. When?	//	////
END ADFs1				
B7. TIME MODULE ENDED: : AM				

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