WOMEN'S INTERAGENCY HIV STUDY
FORM 22 HX: FOLLOW-UP HEALTH HISTORY

SECTION A: GENERAL INFORMATION

A1. PARTICIPANT ID: ENTER NUMBER HERE ONLY IF ID LABEL IS NOT AVAILABLE |___|- |___|___| - |___|___|___|___| - |___|

A2. WIHS STUDY VISIT #: |___|___|

A3. FORM VERSION: **0 4 / 0 1 / 1 7**

A4. DATE OF INTERVIEW: |___|___| / |___|___| / |___|___|
M D Y

A5. INTERVIEWER'S INITIALS: |___|___|___|

A6. DATE FORM LAST ADMINISTERED |___|___| / |___|___| / |___|___|
M D Y

A7. TIME MODULE BEGAN: |___|___| : |___|___| AM..... 1
PM..... 2

INTRODUCTION TO PARTICIPANT:

Now, I am going to ask you some questions about your health history. I will be asking you a series of questions about diseases and symptoms you may have had since your study visit on (MONTH/DAY/YEAR). Also, if at any point in the interview you wish to stop, let me know.

Finally, I need to re-emphasize that all your answers are confidential, and the responses you provide will in no way affect your clinical care.

SECTION B. SYMPTOMS

Since your (MONTH) study visit, have you experienced any of the following:

	YES	NO
B1. a fever for more than one month straight, with a temperature over 100 degrees	**1**	2
B3. major problems with memory or concentration that interfered with your normal, everyday activities, and that lasted for more than two weeks	**1**	2
B4. numbness, tingling, or burning sensations in your arms, legs, hands or feet that lasted for more than two weeks.	**1**	2
B5. an unintentional weight loss, of 10 pounds or more, or have you changed to a smaller clothing size, that lasted more than one month	**1**	2
B6. confusion, getting lost in a familiar place or inability to perform routine mental tasks....	**1**	2
B7. drenching night sweats that soak night clothes or bedding	**1**	2

REFER FOR DIFFERENTIAL DIAGNOSIS TO PARTICIPANT'S MEDICAL PROVIDER

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SECTION C: MEDICAL CONDITIONS AND CONCOMITANT ILLNESSES/SYMPTOMS

For the following questions, I am going to use the words "health care provider" to mean any doctor, nurse, physician's assistant or nurse practitioner you go to for medical care.

PROMPT: IF PARTICIPANT RESPONDS "YES" TO ANY SECTION C ANSWERS THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS AND OBTAIN MEDICAL RECORD RELEASE.

C1. Since your (MONTH) study visit, have you been told by a health care provider that you had any type of cancer, including skin cancer, lymphoma, Kaposi's sarcoma, Hodgkin's disease, breast cancer or cancer of the female organs – the cervix, ovaries or uterus?

YES 1
NO ..... 2 **(C15)**

What kind of cancer? Was it: **[READ C2 - C14]**

		YES	NO/NEVER HEARD OF IT
C2.	Cervical cancer	1	2
C3.	Breast cancer	1	2
C4.	Cancer of the ovary	1	2
C5.	Cancer of the uterus	1	2
C6.	Kaposi's Sarcoma (KS)	1	2
C7.	Lymphoma	1	2
C8.	Lymphoma in the brain	1	2
C9.	Hodgkin's disease	1	2
C10.	Skin cancer (not KS)	1	2
C11.	Cancer of the liver	1	2
C12.	Lung cancer	1	2
C13.	Colon cancer	1	2
C14.	Other	1	2 **(C15)**

SPECIFY: _____

C15. PLEASE RECORD THE TOTAL NUMBER OF CANCERS REPORTED AT THIS VISIT. INCLUDE ALL CANCERS REPORTED IN QUESTIONS C2 – C14. |___|___| # CANCERS

PROMPT: IF QUESTION C15 = 00, SKIP TO QUESTION C21.

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START F22HXS8

PROMPT: FOR EACH CANCER INDICATED IN QUESTION C15, COMPLETE QUESTIONS C16–C17. THE NUMBER OF BOXES COMPLETED MUST EQUAL THE VALUE RECORDED AT C15. INDICATE THE LOCATION OF EACH REPORTED CANCER IN a, THEN COMPLETE c & d AS INDICATED FOR EACH. IF THE TOTAL NUMBER OF REPORTED CANCERS IS GREATER THAN TWO, PLEASE XEROX THIS PAGE AND INSERT THE COPY.

C16. a. LOCATION OF REPORTED CANCER: _____

PROMPT: REPLACE (LOCATION) WITH THE LOCATION WRITTEN IN C16a.

Now I'm going to ask you a few more questions about your (LOCATION) cancer diagnosis.

	YES	NO
c. When your (LOCATION) cancer diagnosis was made, were you told that it had also metastasized or spread to another part of your body?	1 **(d)**	2 **(C17)**

d. Spread to where? _____ **(C17)**

C17. a. LOCATION OF REPORTED CANCER: _____

PROMPT: REPLACE (LOCATION) WITH THE LOCATION WRITTEN IN C17a.

Now I'm going to ask you a few more questions about your (LOCATION) cancer diagnosis.

	YES	NO
c. When your (LOCATION) cancer diagnosis was made, were you told that it had also metastasized or spread to another part of your body?	1 **(d)**	2 **(C18)**

d. Spread to where? _____ **(C18)**

END F22HXS8 .

PROMPT: IF ANY OF C2–C14 = YES, THEN COMPLETE ASCERTAINMENT TRACKING CHECKLIST (ATC) FOR EACH ILLNESS AND OBTAIN MEDICAL RECORD RELEASE. ALSO, IF C16c/C17c = YES, THEN COMPLETE ATC FOR METASTATIC CANCER.

		YES	NO
C18.	Since your (MONTH) study visit have you received cancer chemotherapies?	1	2
C19.	Since your (MONTH) study visit have you received radiation treatments?	1	2

C21. Since your (MONTH) study visit, have you had TB?

YES.....1
NO.....2

PROMPT: IF C21 = YES, THEN COMPLETE ASCERTAINMENT TRACKING CHECKLIST AND OBTAIN MEDICAL RECORD RELEASE.

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C22. I am now going to ask you about other NEW conditions, ailments, or disorders. Were you diagnosed with any of the following since your (MONTH) study visit?

		YES	NO
c.	High blood pressure or hypertension	1	2
d.	High blood sugar, diabetes, or sugar diabetes	1	2
e.	Kidney problem or kidney disease	1	2
f.	Lupus	1	2
g.	Graves' disease or hyperthyroidism	1	2
h.	Hashimoto's thyroiditis or low thyroid hormone	1	2
i.	Multiple sclerosis (MS)	1	2

PROMPT: IF EVEN-NUMBERED VISIT, SKIP TO QUESTION C31.

C23. Are you afraid of falling?

Not at all 1
A little 2
Quite a bit 3
Very much 4

C24. For each of the following, please indicate your level of confidence in doing the activity without losing your balance or becoming unsteady from choosing one of the percentage points on the scale from 0% to 100%. If you do not currently do the activity in question, try and imagine how confident you would be if you had to do the activity. If you normally use a walking aid to do the activity or hold onto someone, rate your confidence as if you were using these supports. If you have any questions about answering any of these items, please ask.

For each of the following activities please indicate your level of self-confidence by choosing a corresponding number from the following rating scale. **SHOW PARTICIPANT RESPONSE CARD ABC-6.**

0%	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**90**	**100%**
No confidence										**Completely confident**

How confident are you that you will not lose your balance or become unsteady when you…

a. Stand on your tiptoes and reach for something above your head? ..... |___|___|___|
b. Stand on a chair and reach for something? ..... |___|___|___|
c. Are bumped into by people as you walk through the mall? ..... |___|___|___|
d. Step onto or off of an escalator while you are holding onto a railing? ..... |___|___|___|
e. Step onto or off of an escalator while you are holding onto parcels ..... |___|___|___|
such that you cannot hold onto the railing?
f. Walk outside on icy sidewalks? ..... |___|___|___|

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C25. Have you had a fall in the past year? By a fall, we mean an unexpected event, including a slip or trip, in which you lost your balance and landed on the floor, ground or lower level, or hit an object like a table or chair. Falls that result from a major medical event (for example, a stroke or seizure) or an overwhelming external hazard (for example, being hit by a truck or pushed), should not be included.

YES 1
NO ..... 2 **(C29)**

C26. How many falls have you had in the past year?

One 1
Two or more 2

C27. Did you seek medical attention after any of these falls (such as going to the emergency room or to a doctor's office)? Respond "NO" if you did not actually see a medical provider because of the fall, but rather sought informal advice from a friend, neighbor, or relative, or communicated with a medical provider by phone or other means (for example, email) without a face-to-face encounter.

YES 1
NO ..... 2 **(C29)**

C28. Did any of these falls result in a broken bone?

YES 1
NO 2

C29. a. In the past year, has a health care provider told you that you had osteopenia or osteoporosis or low bone mineral density (that is, thinning or weakening bones)?

YES 1
NO 2

c. In the past year, has a health care provider told you that you had broken or fractured any of your bone(s)? This could include your spine, hip, arm, or any other bone.

YES 1
NO ..... 2 **(C31)**

C30. In the past year, has a health care provider told you that you had broken or fractured…

	YES	NO
a. Your hip?	1	2 **(b)**
2. Did that fracture occur….		
i. As a result of a fall from standing height or less	1 **(b)**	2
ii. Because of a harder fall	1 **(b)**	2
iii. From a car accident or other severe trauma	1 **(b)**	2
iv. Other SPECIFY: _____ **(b)**	1	2 **(v)**
v. Don't know	1	2

		YES	NO
b.	Your wrist (not including forearm or hand)?	1	2 **(c)**
	2. Did that fracture occur….		
	i. As a result of a fall from standing height or less	1 **(c)**	2
	ii. Because of a harder fall	1 **(c)**	2
	iii. From a car accident or other severe trauma	1 **(c)**	2
	iv. Other ..... SPECIFY: _____ **(c)**	1	2 **(v)**
	v. Don't know	1	2
c.	Your spine?	1	2 **(d)**
	2. Did that fracture occur….		
	i. As a result of a fall from standing height or less	1 **(d)**	2
	ii. Because of a harder fall	1 **(d)**	2
	iii. From a car accident or other severe trauma	1 **(d)**	2
	iv. Other ..... SPECIFY: _____ **(d)**	1	2 **(v)**
	v. Don't know	1	2
d.	Any other bone?	1	2 **(C31)**
	1. SPECIFY LOCATION: _____		
	2. Did that fracture occur….		
	i. As a result of a fall from standing height or less	1 **(C31)**	2
	ii. Because of a harder fall	1 **(C31)**	2
	iii. From a car accident or other severe trauma	1 **(C31)**	2
	iv. Other ..... SPECIFY: _____ **(C31)**	1	2 **(v)**
	v. Don't know	1	2

C31. (Since your (MONTH) study visit, were you diagnosed with) liver cirrhosis?

YES 1
NO ..... 2 **(C32)**

These are other conditions that can be a consequence of liver cirrhosis.

i. Since your (MONTH) study visit, have you had abnormal fluid in the belly (ascites)?

YES 1
NO 2

ii. (Since your (MONTH) study visit, have you had) bleeding from enlarged veins in your esophagus or stomach (varices)?

YES 1
NO 2

iii. (Since your (MONTH) study visit, have you had) hepatic encephalopathy (confusion or decreased awareness caused by liver disease)?

YES 1
NO 2

C32. FROM VISIT CONTROL SHEET (VCS), IS PARTICIPANT HEPATITIS C POSITIVE?

YES ..... 1 **(C35)**
NO 2

C33. Since your (MONTH) study visit, have you had a new diagnosis of hepatitis C?

YES 1
NO ..... 2 **(C39)**

C35. Since your (MONTH) study visit, have you talked to a doctor or medical provider about Hepatitis C treatment?

YES ..... 1 **(C36)**
NO 2

b. Why not? (CIRCLE "YES" FOR ALL THAT APPLY.)

		YES	NO	
i.	I have already completed treatment prior to my last visit	1	**(C37e)** 2	
ii.	I feel healthy enough without Hepatitis C treatment	1	2	
iii.	I have too many other health problems to worry about Hepatitis C	1	2	
iv.	I don't have enough money to pay for Hepatitis C treatment	1	2	
v.	I've heard Hepatitis C treatment doesn't work	1	2	
vi.	I've heard Hepatitis C treatment can make you sick	1	2	
vii.	Other reason	1	2	**(C36)**

SPECIFY: _____

C36. Have you ever been referred to a clinic, doctor, or medical provider who provides treatment for Hepatitis C?

YES 1
NO ..... 2 **(C39)**

a. Did the doctor or medical provider recommend you take medications to treat your Hepatitis C?

YES 1
NO 2

C37. Since your (MONTH) study visit, have you taken medications for Hepatitis C?

YES ..... 1 **(C37b)**
NO 2

a. Why haven't you taken medications for Hepatitis C? (CIRCLE "YES" FOR ALL THAT APPLY.)

	YES	NO
i. I have previously completed treatment	1 **(C37e)**	2
ii. My health insurance would not pay all or enough of the cost for treatment	1	2
iii. I am scared to take Hepatitis C medications	1	2
iv. I don't believe I need Hepatitis medications	1	2
v. I don't believe the Hepatitis medications work	1	2
vi. Because my liver disease is not advanced	1	2
vii. Because I have HIV/AIDS	1	2
viii. Because I am black or Hispanic/Latina	1	2
ix. Because I have another illness that makes hepatitis medicine too risky	1	2
x. Because I have the wrong Hepatitis C genotype	1	2
xi. Because I have blood test abnormalities	1	2
xii. Because I should wait for better Hepatitis C medications to become available	1	2
xiii. Other reason	1	2 (**C39)**

SPECIFY: _____ **(C39)**

b. Are you currently taking Hepatitis C medications?

YES ..... 1 **(C39)**
NO 2

c. Have you completed treatment?

YES ..... 1 **(C37e)**
NO 2

d. What was the MAIN reason or reasons that you stopped taking medications for Hepatitis C? If you stopped more than once, tell me only about the most recent time. **(CIRCLE "YES" FOR ALL THAT APPLY.)**

	YES	NO
i. Therapy was unsuccessful	1	2
ii. I had a low white blood cell count (leukopenia)	1	2
iii. I had a low red blood cell count (anemia)	1	2
iv. I had psychological side effects	1	2
v. I'm having a baby	1	2
vi. My health care provider stopped it, but I don't know why	1	2
vii. I had other blood test abnormalities	1	2
viii. It required too many visits	1	2

	YES	NO
ix. It was too expensive/my insurance didn't cover treatment	1	2
x. I was not able to keep all the appointments	1	2
xi. Other reason	1	2

SPECIFY: _____

e. Did your provider tell you the treatment was successful, called a cure, an SVR or a sustained viral response?

YES 1
NO 2

C39. Have you been told by a health care provider that you needed a liver transplant since your (MONTH) study visit?

YES 1
NO ..... 2 **(C42)**

C40. Have you had a liver transplant since your (MONTH) study visit?

YES 1
NO 2

C41. Are you currently on a waiting list for a liver transplant?

YES 1
NO 2

C42. Since your (MONTH) study visit, has a health care provider told you that you had…

	YES	NO	DON'T KNOW
a. A new diagnosis of angina or chest pain related to heart disease	1	2 **(b)**	<-8> **(b)**
i. Were you hospitalized for angina or chest pain due to heart disease?	1	2	<-8>
b. A new diagnosis of congestive heart failure or CHF	1	2 **(c)**	<-8> **(c)**
i. Were you hospitalized for congestive heart failure?	1	2	
c. A heart attack or myocardial infarction or MI	1	2	<-8>
d. A stroke or CVA	1	2	<-8>
e. A transient ischemic attack or TIA or "mini-stroke"	1	2	<-8>

C44. Since your (MONTH) study visit, have you had any surgery or procedure to look for or to open blocked vessels in your heart or other areas of your body? (**PROBE**: Your doctor may have called this: cardiac catheterization, percutaneous revascularization, PTCA, angioplasty, stenting, carotid endarterectomy, surgical revascularization, CABG, or coronary artery bypass grafting.)

YES 1
NO ..... 2 **(C46)**

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		YES	NO	
Was this procedure or surgery done on:				
a.	Your heart vessels?	1	2	**(b)**
	i. What was done? _____			
b.	Other vessels?	1	2	**(C46)**
	i. What was done? _____			

C46. IS THIS AN EVEN-NUMBERED VISIT, OR WAS PARTICIPANTS LAST VISIT MVIS OR ABRV?

YES 1
NO ..... 2 **(C49)**

C47. In the past year, have you had a serious head injury – that is, had an injury to your head, scalp, or brain? (**PROBE:** A serious head injury may also be associated with dizziness, confusion, pain that lasts after the injury, a loss of consciousness, or needing a hospital visit.)

YES 1
NO ..... 2 **(C49)**

a. How many head injuries have you had? |___|___|___|
HEAD INJURIES

START F22HXS10

PROMPT: FOR EACH HEAD INJURY INDICATED IN QUESTION C47a, COMPLETE QUESTIONS C48a-g. THE NUMBER OF SUBFORMS COMPLETED MUST EQUAL THE VALUE RECORDED AT C47a. IF THE TOTAL NUMBER OF REPORTED HEAD INJURIES IS GREATER THAN ONE, PLEASE XEROX THIS PAGE AND INSERT THE COPY.

C48. Now I'd like to ask some questions about each of these injuries. Let's start with the earliest one.

a. How did it happen?

Had a fall and hit head 1
Car accident 2
Sports injury 3
Physical violence 4
Other 5

SPECIFY: _____

b. How old were you when it happened? |___|___| YEARS

		YES	NO	
c.	Did you see a doctor because of the injury?	1	2	
d.	Did you stay overnight in a hospital because of the injury?	1	2	
e.	Did you lose consciousness or were you "knocked out" because of the injury?	1	2	**(f)**

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i. How long were you unconscious? (**PROBE:** How many minutes?)

|___|___|___| MINUTES 1
HOURS 2
DAYS 3

		YES	NO
f.	Did you have a skull fracture?	1	2
g.	Did you have a seizure or fit within 7 days after the head injury?.....	1	2

END F22HXS10 .

C49. Are you currently on dialysis?

YES 1
NO 2

C50.

Since your (MONTH) study visit, has a health care provider, either a doctor, dentist, nurse practitioner, nurse, or physician's assistant, told you that you had **(CONDITION)?**			How many different times in the past 6 months did you have this?
Shingles (Herpes Zoster)?	YES..... 1 NO 2	**(SECT. E)**	a. |__|__| # TIMES
b. Have you had 2 or more separate areas with shingles at the same time?	YES..... 1 NO 2		

SECTION E: AIDS DEFINING ILLNESSES

E0. PARTICIPANT'S CURRENT HIV STATUS:

POSITIVE 1
NEGATIVE ..... 2 **(E26)**

We are now interested in finding out about diseases that some women, especially those with HIV, can experience. Many of the terms in this section are very technical and you may not have heard of them. If you've never heard of a term just say so. Since your (MONTH) study visit, has a health care provider told you that you have had any of the following AIDS-related illnesses?

		YES	NO
E1.	Herpes simplex with ulcers or sores lasting longer than one month?	1	2
E2.	Herpes simplex infection of the lungs or esophagus, (the tube between your mouth and your stomach)?.....	1	2
E3.	Pneumocystis jirovecii or PCP, pneumocystis carinii pneumonia?	1	2
E4.	Another type of pneumonia or lung infection? (Do not answer yes if you were diagnosed only with bronchitis).....	1	2
E5.	Candida or thrush, a yeast infection of the esophagus (the tube between your mouth and stomach) not just in your mouth, or a yeast infection of the lungs or airways (trachea or bronchi)?.....	1	2
E6.	An M-A-I infection, which is sometimes called M-A-C or MAC?	1	2

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		YES	NO	
E7.	Toxo infection, or toxoplasmosis of the brain?	1	2	
E8.	C-M-V, cytomegalovirus, anywhere in your body, including eye blood, intestine, liver, or elsewhere?	1	2	
E9.	Meningitis related to HIV?	1	2	**(E11)**
E10.	Crypto or Cryptococcal meningitis?	1	2	
E11.	Cryptococcal infection anywhere in your body, including blood or elsewhere in your body?	1	2	
E12.	Histoplasmosis infection or Histo?	1	2	
E13.	Cocci, coccidioidomycosis infection or Valley Fever?	1	2	
E14.	Wasting syndrome?	1	2	
E15.	Dementia or encephalopathy, or that you had memory problem or confusion caused by HIV?	1	2	
E16.	An infection in the blood with bacteria called salmonella?	1	2	
E17.	PML, progressive multifocal leukoencephalopathy, a disease of the brain?	1	2	

E26. TIME MODULE ENDED |__|__| : |__|__| AM 1
PM 2