Visit 68 CADI Form

Instructions: This form is to be used as a paper back-up for the CADI. Fill out the responses on this form and data enter the responses into the CADI by initiating a CADI session for this MACSID. Since the date and time began and ended are automatically populated by the CADI, scan in this front page and the time ended and email to Andrea Stronski (astrons2@jhu.edu). CAMACS will update the CADI session for the MACSID with the correct dates and times. Keep a copy of each completed CADI paper form for your records.

*** = abbreviated interview questions. Administer all embedded questions within a skip pattern for abbreviated interview questions.**

* MACSID NUMBER (enter twice) ___ ___ ___ ___ ___ ___ ___ ___ ___ ___

* Visit Number: V067

* TIME BEGAN				
HOUR		MINUTES		AM/PM

* DATE OF VISIT					
MONTH		DAY		YEAR	

* Date of Last Visit **[in (Month, Year)]** ___ ___ / ___ ___ ___ ___

* Date of birth **[MM/DD/YYYY]** ___ ___ / ___ ___ / ___ ___ ___ ___ *(8 Characters)*

* **Q1.** Let's start with some medical conditions. Since your last visit **[in (MONTH, YEAR)],** were you diagnosed with ANY form of cancer? We are interested in all cancers, such as Kaposi's sarcoma, non-Hodgkin's lymphoma, anal, lung, prostate cancers, primary brain lymphoma, Hodgkin's disease, and Castleman's disease.

☐ NO [*GO TO **Q2***]

☐ YES [*GO TO **Q1.A1***]

☐ REF [*GO TO **Q2***]

Q1.A. **IF YES:** Where in the body was the cancer (Castleman's disease) and what kind of cancer did they say it was?

	1. 1st Cancer	**2. 2nd Cancer**
Cancer Code: (See MACS cancer codes)	___ ___ . ___ ___	___ ___ . ___ ___
Type of Cancer:		
Site of Cancer:		

Visit 68 CADI Form

	1. 1st Cancer	2. 2nd Cancer
Medical Release Obtained:	☐ REF ☐ YES	☐ REF ☐ YES
Q1.B. In what month and year was it first diagnosed since your last visit **[in (MONTH, YEAR)]?**	__ __ / __ __ __ __ Month Year	__ __ / __ __ __ __ Month Year

Q1.C1. What was the name and address of the physician who diagnosed the first cancer?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **DATE:** __ __ / __ __ / __ __ __ __
Month Day Year

Q1.C2. What was the name and address of the physician who diagnosed the second cancer (if different from the first)?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **DATE:** __ __ / __ __ / __ __ __ __
Month Day Year

* **Q2.** 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 [*GO TO Q3*]

☐ YES [*GO TO Q2.A*] → **Medical Release Obtained? ☐ REF ☐ YES**

☐ REF [*GO TO Q3*]

Q2.A. IF YES: What was the diagnosis?

	1. 1st Diagnosis	2. 2nd Diagnosis
What was the diagnosis?		
Description of AIDS diagnosis:		
Code:	__ __ . __ __	__ __ . __ __

Visit 68 CADI Form

	1. 1st Diagnosis	2. 2nd Diagnosis
Q2.B. In what month and year was it first diagnosed since your last visit **[in (MONTH, YEAR)]?**	__ __ / __ __ __ __ Month Year	__ __ / __ __ __ __ Month Year
	If Q2 YES, then Q2.B must be entered	

* **Q3.** Since your last visit **[in (MONTH, YEAR)],** were you diagnosed with pneumonia?

☐ NO [*GO TO Q4*]
☐ YES [*GO TO Q3.A*] → **Medical Release Obtained? ☐ REF ☐ YES**
☐ REF [*GO TO Q4*]

Q3NOTES:
Clinician's Notes: Method of Diagnosis (30 Characters)
_____
_____
_____
_____
_____

Q3.A. In what month and year since your last visit **[in (MONTH, YEAR)]** was it first diagnosed?

__ __ / __ __ __ __
Month Year

Q3.B. What was the name and address of the physician who diagnosed the condition?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **DATE:** __ __ / __ __ / __ __ __ __
Month Day Year

* **Q.4.A.** Since your last visit **[in (MONTH, YEAR)]**, did you have a skin **or blood** test for TB, sometimes called a PPD?

***PPD* is the skin test and *Quantiferon* is the blood test**

☐ NO [*GO TO Q5*] ☐ YES ☐ REF [*GO TO Q5*]

Q4.B. IF YES: When was your last test? __ __ / __ __ __ __ **[MM/YYYY]**

Q4.C. Was it positive? ☐ NO ☐ YES ☐ REF

* **Q5.** Since your last visit **[in (MONTH, YEAR)]** have you had an active TB infection?

☐ NO
☐ YES → **Medical Release Obtained? ☐ REF ☐ YES**
☐ REF

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____ **DATE:** ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

* **Q6.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.

☐ NO [*GO TO Q7*]
☐ YES [*GO TO Q6.A1*] → **Medical Release Obtained? ☐ REF ☐ YES**
☐ REF [*GO TO Q7*]

Q6.A1. How many separate times were you a patient in a hospital since your last visit **[in (Month, Year)]?**

___ ___

[If a participant reports that he was hospitalized for a reportable outcome, request medical records]

Q6.B. Tell me about (that hospitalization/outpatient procedure/each of those times) starting with the most recent hospitalization/outpatient procedure.

Q6.B1a. On what date did you last go into the hospital? ___ ___ /___ ___ /___ ___ ___ ___
Month Day Year

Q6.B1b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

___ ___

Q6.B1c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R's OWN WORDS. Leading zeroes for ICDS-cm codes.
"V"= no disease or injury (e.g., organ donation)
"E"= external causes of injury (e.g., car accident)
"P"= procedures (enter leading zero)
"NP"= no prefixes (all other diagnosis)

IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Diagnosis:_____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: __ __.__ __

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____- STATE _____ DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Q6.B2a. For your second most recent time to the hospital, on what date did you go into the hospital?

___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Q6.B2b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

_____ _____

Q6.B2c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R's OWN WORDS. Leading zeroes for ICDS-cm codes.
"V"= no disease or injury (e.g., organ donation)
"E"= external causes of injury (e.g., car accident)
"P"= procedures (enter leading zero)
"NP"= no prefixes (all other diagnosis)

IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Diagnosis:_____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: __ __.__ __

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____- STATE _____ DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Q6.B3a. For your third most recent time to the hospital, on what date did you go into the hospital?

___ ___ / ___ ___ / ___ ___ ___ ___
Month *Day* *Year*

Q6.B3b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

_____ _____

Q6.B3c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R's OWN WORDS. Leading zeroes for ICDS-cm codes.
"V"= no disease or injury (e.g., organ donation)
"E"= external causes of injury (e.g., car accident)
"P"= procedures (enter leading zero)
"NP"= no prefixes (all other diagnosis)

IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Diagnosis:_____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: __ __.__ __

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____- STATE _____ DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Q6.B4a. For your fourth most recent time to the hospital, on what date did you go into the hospital?

___ ___ / ___ ___ / ___ ___ ___ ___
Month *Day* *Year*

Q6.B4b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

_____ _____

Q6.B4c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R's OWN WORDS. Leading zeroes for ICDS-cm codes.
"V"= no disease or injury (e.g., organ donation)
"E"= external causes of injury (e.g., car accident)
"P"= procedures (enter leading zero)
"NP"= no prefixes (all other diagnosis)

IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE

Diagnosis:_____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: __ __ __.__

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: __ __.__ __

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____- STATE _____ DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Q7. Since your last visit **[in (MONTH, YEAR)],** have you consulted a mental health professional or been hospitalized or prescribed medications for treatment of depression?

☐ NO [*GO TO **Q8***] ☐ DON'T KNOW [*GO TO **Q8***]
☐ YES ☐ REF [*GO TO **Q8***]

IF YES: which month and year was the most recent time? ___ ___ / ___ ___ ___ ___
Month Year

Q8. 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 ☐ REF

[*IF YES, RECORD DIAGNOSES IN **Q10.CCi** (Nervous System)*]

*** Q9.A1.** Since your last visit **[in (MONTH, YEAR)]**, have your undergone an anal pap smear? (a doctor or medical practitioner took a swab of the anal canal to test for cancer cells.)
This does not include any anal PAP smears performed as part of the MACS Anal Health Study.

☐ NO [*GO TO **Q9.B***] ☐ DON'T KNOW [*GO TO **Q9.B***]
☐ YES [*GO TO **Q9.A2***] ☐ REF [*GO TO **Q9.B***]

Q9.A2. In what month and year did you have a pap smear performed? ___ ___ / ___ ___ ___ ___
Month Year

Q9.A3. Were the results abnormal?

☐ NO [*GO TO **Q9.B***]
☐ YES → **Medical Release Obtained? ☐ REF ☐ YES**
☐ DON'T KNOW → **Medical Release Obtained? ☐ REF ☐ YES**
☐ REF [*GO TO **Q9.B***]

Q9.A4. Name of the doctor who performed the pap smear and where it was performed.

Name of Hospital/clinic or doctor: _____

ADDRESS:
_____

CITY: _____ STATE _____ DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

***Q9.B.** Since your last visit **[in (MONTH, YEAR)]**, has a doctor or medical practitioner inserted a tube-shaped device or scope in your anus or rectum to look for hemorrhoids, fissures, infections and some cancers? This is also known as a High Resolution Anascopy (HRA).

☐ NO
☐ YES
☐ DON'T KNOW
☐ REF

If yes or don't know, request medical records. If an HRA was performed based on the review of the medical records, fill out an HRA Outcome Reporting form to indicate if a biopsy was performed and the biopsy results. Submit to CAMACS. See MACS forum for protocols.

Q9.C1. Since your last visit **[in (MONTH, YEAR)]**, did you experience anal bleeding at any time?

(If participant asks why: "The information that we gather about symptoms will help researchers learn how symptoms are related to the risk of developing certain illnesses or diseases. Understanding this relationship will help doctors and nurses do a better job in detecting and diagnosing illnesses.")

☐ NO [*GO TO **Q9.D***] ☐ YES [*IF YES, GO TO **Q9.C2***] ☐ REF [*GO TO **Q9.D***]

Q9.C2. Since your last visit **[in (MONTH, YEAR)]**, have you experienced any pain with the anal bleeding?

☐ NO [*GO TO **Q9.C4***] ☐ YES [*GO TO **Q9.C3***] ☐ REF [*GO TO **Q9.C4***]

Q9.C3. Since your last visit **[in (MONTH, YEAR)]**, how often have you experienced pain with the anal bleeding?

☐ Rarely ☐ Most of the time
☐ Some of the time ☐ All of the time

Visit 68 CADI Form

Q9.C4. Since your last visit **[in (MONTH, YEAR)]**, has the bleeding occurred in any of the following situations?

[READ EACH ITEM]

Q9.C4a. After or during anal receptive intercourse ☐ NO ☐ YES ☐ REF

Q9.C4b. After or during a bowel movement ☐ NO ☐ YES ☐ REF

Q9.C4c. Other times not associated with intercourse or bowel movements

☐ NO [*GO TO **Q9.D1***] ☐ YES [*GO TO **Q9.C5***] ☐ REF [*GO TO **Q9.D1***]

Q9.C5. With respect to the *other times* (that you have had anal bleeding), how often have you experienced bleeding since your last visit **[in (MONTH, YEAR)]**?

☐ Daily ☐ Weekly ☐ Monthly ☐ Less than monthly

*** Q9.D1.** Since your last 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. READ: This includes any biopsies you have had as part of the MACS Anal Health Study. **If reported cancer, ask about biopsy for the cancer.**

☐ NO [*GO TO **Q9.10A***]

☐ YES [*GO TO **Q9.D2***] → **Medical Release Obtained? (See Q1)** ☐ **REF** ☐ **YES**

☐ REF [*GO TO **Q9.10A***]

Q9.D2. How many times have you had a biopsy since your last visit **[in (MONTH, YEAR)]?**

____ _____

Q9.D3. For each biopsy, please tell me (See Appendix 2 & 3 in the Medical History guidelines)

BIOPSY	**1)**	**2)**	**3)**
Q9.D3a. Where in your body?	Site Code: ____ _____ Specify: _____	Site Code: ____ _____ Specify: _____	Site Code: ____ _____ Specify: _____
Q9.D3b. What did they say the diagnosis or result of the biopsy was?	DX Code: ____ _____ Specify: _____	DX Code: ____ _____ Specify: _____	DX Code: ____ _____ Specify: _____
Q9.D3c. Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ___ ___ /___ ___/___ ___	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ___ ___ /___ ___/___ ___	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ___ ___ /___ ___/___ ___

***Q10.** I am now going to ask you about other **NEW** conditions, ailments or disorders. Were you diagnosed with any of the following since your last visit **[in (MONTH, YEAR)]**?

***A.** Thrush (yeast in your mouth)	☐ NO	☐ YES	☐ REF	
***B.** Sinusitis, a sinus infection that requires antibiotics	☐ NO	☐ YES	☐ REF	
***C.** Bronchitis	☐ NO	☐ YES	☐ REF	
***D.** Erectile dysfunction (erectile problems)	☐ NO	☐ YES	☐ REF	
***E.** High blood pressure or hypertension	☐ NO	☐ YES	☐ REF	
***F.** High cholesterol, high triglycerides, high lipids or too much fat in your blood	☐ NO	☐ YES	☐ REF	
***G.** High blood sugar or diabetes	☐ NO	☐ YES	☐ REF	
***H.** Arthritis	☐ NO	☐ YES	☐ REF	

IF YES: Was it:

▪ Rheumatoid	☐ NO	☐ YES	☐ DK	☐ REF
▪ Osteoarthritis or Degenerative	☐ NO	☐ YES	☐ DK	☐ REF
▪ Other	☐ NO	☐ YES	☐ DK	☐ REF

Specify Other:

Obtain a medical release for each item below with a "YES" response for items Q10.I - Q10.Q.

***I.** Angina or chest pain caused by your heart	☐ NO	☐ YES	☐ REF
***J.** Heart attack or myocardial infarction (MI)	☐ NO	☐ YES	☐ REF
***K.** Congestive heart failure or CHF	☐ NO	☐ YES	☐ REF
***L.** Stroke or Cerebrovascular accident (CVA)	☐ NO	☐ YES	☐ REF
***M.** Mini-strokes or transient ischemic attacks (TIA)	☐ NO	☐ YES	☐ REF
***N.** Too fast, too slow, or irregular heart beat	☐ NO	☐ YES	☐ REF
***O.** Any blood vessels (arteries) that were blocked or closed	☐ NO	☐ YES	☐ REF
***P.** An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas	☐ NO	☐ YES	☐ REF
***Q.** A blood clot in your legs	☐ NO	☐ YES	☐ REF
***R.** Kidney disease/Renal failure	☐ NO	☐ YES	☐ REF
***S.** Elevated Liver Enzyme	☐ NO	☐ YES	☐ REF

Visit 68 CADI Form

What was the name and address of the physician who diagnosed the condition(s)? If more than one diagnosis, ask if same or different doctors.

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____DATE: ___ ___ / ___ ___ / ___ ___ ___ ___
Month Day Year

Administration: These are baseline questions and will be administered one time to all participants and followed up with since your last visit question every visit going forward. **Both sets are listed below. Only complete the baseline for participants who have not been administered this section in the past. Otherwise, skip to the Bone Strength Sub Study question (T1).**

Introduction:
We are now going to ask you about heart problems that may have been diagnosed prior to age 55 among the men and prior to age 65 among the women in your immediate family. Immediate family comprises your biological father, mother, brothers and sisters.

☐ **Mark here for those participants who do not know them because they are adopted.**

Interviewer note: *Questions apply to all living and deceased immediate family members. If a participant's family member was diagnosed with a heart attack and later died of a heart attack before age 55 if male or age 65 if female, fill in yes for both questions for this same family member. Similarly, if diagnosed with a heart attack and had surgery, fill in yes for both questions. All events have to occur prior to age 55 for men and age 65 for women. If the participant is not sure, mark DK. If he is able to contact you after the interview with a definite answer, update the CADI with this new information*

Q10.fam (IF the participant was administered these questions at V61, then go to Q10.fam – Since Last Visit)

1. Has a male member of your immediate family

a) ever been diagnosed with a Heart Attack before age 55?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

b) ever died from a Heart Attack before age 55?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

2. Has a female member of your immediate family

a) ever been diagnosed with a Heart Attack before age 65?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

b) ever died from a Heart Attack before age 65?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

3. Has a male member of your immediate family

a) ever had heart bypass surgery before age of 55?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

b) ever had an angioplasty with or without a stent before the age of 55?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

4. Has a female member of your immediate family

a) ever had heart bypass surgery before age of 65?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

b) ever had an angioplasty with or without a stent before the age of 65?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

Q10.fam – Since Last Visit

1. **Since your last visit, h**as a male member of your immediate family

a) been diagnosed with a Heart Attack before age 55?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

b) died from a Heart Attack before age 55?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

2. Since your last visit has a female member of your immediate family

a) been diagnosed with a Heart Attack before age 65?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

b) died from a Heart Attack before age 65?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

3. Since your last visit has a male member of your immediate family

a) had heart bypass surgery before age of 55?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

b) had an angioplasty with or without a stent before the age of 55?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

4. Since your last visit has a female member of your immediate family

a) had heart bypass surgery before age of 65?

☐ NO
☐ YES
☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
☐ REF

b) had an angioplasty with or without a stent before the age of 65?

☐ NO

☐ YES

☐ DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

☐ REF

"We have completed the family questions. Now let's return to questions about your own medical conditions since your last visit in (month, year)"

***T.2.Intro** "We are now going to ask you some questions about falls that may have happened during your usual daily activities. For the following questions, by "a fall" or "falling", 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, hit by a truck or pushed) should not be included."

T.2a. Since your last visit, have you been concerned with losing your balance and falling while doing your usual daily activities? Would you say not at all, a little, quite a bit or very much?

☐ NOT AT ALL
☐ A LITTLE
☐ QUITE A BIT
☐ VERY MUCH
☐ DK
☐ REF

T.2b. How many times have you fallen since your last visit?

☐ None ***Go to Q10. (cont.)***
☐ 1 time
☐ 2 times
☐ 3-5 times
☐ More than 5 times
☐ DK
☐ REF

T.2c. Did you seek medical attention after any of these falls (such as calling 911, going to the emergency room or to a doctor's office)? **INTERVIEWER NOTE:** Answer "No", if the participant did not see a medical provider (nurse, physician, paramedic, etc.) in-person. For example, answer NO if he asked a friend for advice, or contacted a medical provider, but was not examined by one.

☐ NO ☐ YES ☐ DK ☐ REF

***T3**. Since your last visit, Broken or fractured bones ☐ NO ☐ YES ☐ REF

*[IF NO OR REF, GO TO **Q10.CCa**]*

***T4.** What was fractured?

[See Appendix Q9A in Guidelines for ICD9 codes]

_____ ___ ___ ___.___

_____ ___ ___ ___.___

_____ ___ ___ ___.___

***T5.** Did that fracture occur…. (Select one)

☐ Without any trauma or fall (i.e., without any external force,: examples, rib fracture when coughing; spine fracture from lifting a heavy box)

☐ As a result of a fall from standing height or less (includes falls due to slipping or tripping)

☐ Because of a harder fall (example, falling down steps)

☐ From a car accident or other severe external force

☐ Don't know

***Q10.CC.** Since your last visit [in (MONTH, YEAR)], have you seen a health care provider, or have gone to a clinic, urgent care facility, or emergency room or any OTHER NEW conditions or problems in the following areas?

Q10.CCa. Eyes ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCa3***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

a3. When was the last time you went to see a doctor, ophthalmologist, or eye specialist concerning your vision?

☐ Less than 1 year
☐ At least 1 year but less than 2 years
☐ At least 2 years but less than 3 years
☐ 3-10 years
☐ Greater than 10 years
☐ REF

a4. At the present time, would you say your eyesight, with glasses or contact lenses if you wear them is:

☐ Excellent
☐ Good
☐ Fair
☐ Poor
☐ Very Poor
☐ DK
☐ REF

Q10.CCb. Ears, Nose, Throat, Mouth and Sinuses ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCc***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Q10.CCc. Heart and Blood Vessels **[Ask if in CV3 study and it had follow up. If yes, get medical release]**

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCd***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Get Medical Release if answer to **heart condition** is yes.

Q10.CCd. Lungs and Bronchial Tubes ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCd1***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Get Medical Release if answer to **lung condition** is yes.

d1. Which of the following types of activities bring on shortness of breath?

☐ 1) Ordinary physical activity does not cause shortness of breath (dyspnea).

You can carry 24lbs (such as a toddler) up eight steps; do heavy lifting; do outdoor work [shovel snow, spade soil]; do recreational activities [skiing, basketball, jog/walk 5 miles per hour]

☐ 2) You are comfortable at rest, but ordinary physical activity results in shortness of breath (dyspnea)

You can do activities such as garden, rake, weed, dance, walk 4 miles per hour on level ground without stopping.

☐ 3) You are comfortable at rest, but less than ordinary physical activity causes shortness of breath (dyspnea)

You can do activities such as shower without stopping, strip and make bed, play golf, dress without stopping, walk about 2.5 miles per hour.

☐ 4) You cannot carry on any physical activity without shortness of breath (dyspnea)

Cannot carry out any activities listed above.

d2. Is there known lung disease or other causes for dyspnea? ☐ NO ☐ YES ☐ REF

d3. Other comments? _____

_____

Q10.CCe. Esophagus, Stomach, Intestines, or Liver Disease ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCf***]

Get Medical Release if answer to **liver disease** is yes.

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Liver Diagnosis: ☐ NO ☐ YES ☐ REF

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____**DATE:** ___ ___ / ___ ___ / ___ ___ ___ ___
Month **Day** **Year**

Q10.CCf. Bones**,** Joints or Muscles ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCg***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Osteoporosis, Avascular Necrosis or Osteonecrosis: ☐ NO ☐ YES ☐ REF

Get Medical Release if osteoporosis, avascular necrosis or osteonecrosis

Q10.CCg. Genital, Urinary and Rectal ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCh***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Q10.CCh. Skin ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCi***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF

What was the diagnosis? _____

_____

Q10.CCi. Nervous system ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q10.CCj***]

Get Medical Release if answer to **nervous system** is YES.

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF
What was the diagnosis? _____

_____

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____**DATE:** ___ ___ / ___ ___ / ___ ___ ___ ___
Month **Day** **Year**

Q10.CCj. Treatment of depression, anxiety, or other mental health problems? ☐ NO ☐ YES ☐ REF
[*IF NO OR REF, GO TO* ***Q10.CCk***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF
What was the diagnosis? _____

_____

Q10.CCk. Hormones or Endocrine system ☐ NO ☐ YES ☐ REF
[*IF NO OR REF, GO TO* ***Q10.CCb***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF
What was the diagnosis? _____

_____

Q10.CCl. Other ☐ NO ☐ YES ☐ REF
[*IF NO OR REF, GO TO* ***Q11.A***]

IF YES: Was there a diagnosis? ☐ NO ☐ YES ☐ REF
What was the diagnosis? _____

_____

Q11.A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, since your last visit **[in MONTH, YEAR)]?**

_____ _____

Q11.A1. Facial herpes, cold sores, or fever blisters ☐ NO ☐ YES ☐ REF

Q11.A2. Sores in genital region ☐ NO ☐ YES ☐ REF

Q11.A3. Sores in the anal or rectal areas ☐ NO ☐ YES ☐ REF

Q11.A4. Sores elsewhere on your body ☐ NO ☐ YES ☐ REF

[*IF NO OR REF TO ABOVE, GO TO **Q12***]

Q11.B. Did the first attack of herpes you ever had occur since your last visit **[in (MONTH, YEAR)]**?

☐ NO ☐ YES ☐ REF

Q11.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?

☐ NO ☐ YES ☐ REF

Q12. Have you had any of the following diseases or conditions since your last visit **[in (MONTH, YEAR)]**? How about **(EACH)**?

Q12.A1. Syphilis ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q12.B**. IF YES, GO TO **Q12.A2***]

Q12.A2. Was this a new infection or was it a continuation or relapse of a previous infection?

☐ New infection ☐ Continued or relapse

Q12.B. Any form of gonorrhea ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q12.F**. IF YES, GO TO **Q12.C***]

Q12.C. Urethral gonorrhea (clap or drip of the urinary passage) ☐ NO ☐ YES ☐ REF

Q12.D. Oral gonorrhea (of the mouth or throat) ☐ NO ☐ YES ☐ REF

Q12.E. Rectal gonorrhea (of the rectum) ☐ NO ☐ YES ☐ REF

Q12.F. Non-specific or nongonococcal urethritis or chlamydia (that is, a discharge from the penis that's not caused by gonorrhea) ☐ NO ☐ YES ☐ REF

Q12.G1. Genital warts (condylomata acuminata) ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q12.H1**. IF YES, GO TO **Q12.G2***]

Q12.G2. Was this a new infection or was it a continuation or relapse of a previous infection?

☐ New infection ☐ Continued or relapse

Q12.H1. Anal warts (condylomata acuminata) ☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q13.A1**. IF YES, GO TO **Q12.H2***]

Q12.H2. Was this a new infection or was it a continuation or relapse of a previous infection?

☐ New infection ☐ Continued or relapse

Visit 68 CADI Form

Q13.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, AND e.	**(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?
1) Persistent dizziness for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
7) Diarrhea for at least 3 consecutive days	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
8) Drenching sweats at night on at least 3 occasions	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
9) Nausea, vomiting	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
10) Abdominal pain, bloating, cramps	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
11) Ascites (fluid buildup in the stomach or abdomen	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
***13)** An unintentional weight loss of at least 10 pounds unrelated to dieting	☐ NO ☐ YES		☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
14) Muscle pain or weakness	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
15) Joint pain	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	(a) How about (EACH)? Did you have that at any time since your 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?
				☐ DK	
16) Vivid nightmares or dreams	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
17) Insomnia or problems sleeping	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES
18) Persistent dry mouth	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES	☐ NO ☐ YES ☐ DK	☐ NO ☐ YES

Q13.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 DK
1. Pain, aching, or burning in your feet or legs?	☐ ☐	Right _____ (0-10) Left _____ (0-10)	☐ ☐ ☐
2. Pins and needles in your feet or legs?	☐ ☐	Right _____ (0-10) Left _____ (0-10)	☐ ☐ ☐
3. Numbness (lack of feeling) in your feet or legs?	☐ ☐	Right _____ (0-10) Left _____ (0-10)	☐ ☐ ☐

Moving on to medications and vaccines for HIV.

Q14.1. Since your last visit, [in (MONTH, YEAR)], have you been given **a vaccine** ***or a therapeutic vaccine to control HIV infection*** as part of a research trial?

Preventive trials study the efficacy of vaccines developed to prevent HIV infection and therapeutic vaccine trials study the efficacy of vaccines to control HIV infection by boosting the body's natural immune response and sometimes delaying the need for initiating antiretroviral drug treatment.

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO* ***Q15****. IF YES, GO TO* ***Q14.2*** *(MUST BE FILLED OUT) AND THEN GO TO* ***Q14.3***]

[*OPTIONAL – DOESN'T HAVE TO BE FILLED OUT*]

See http://www.aidsinfo.nih.gov/clinical-trials/.
If not identifiable based on information from participant, obtain a medical release to get name and NCT number from his doctor.

Q14.2. What is the name of the trial?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ **STATE** _____**DATE:** ___ ___ / ___ ___ / ___ ___ ___ ___
Month **Day** **Year**

Q14.3. **MACS CODE for Clinical/Vaccine Trial:** _____ _____ _____ _____

**[*IF NO MACS CODE, CONTACT CAMACS.*
SEE MACS FORUM - VACCINE AND CLINICAL RESEARCH TRIALS]**

***** **Q15.** 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.) .This does not include medications to prevent getting infected with HIV. Questions about this type of treatment are asked separately. Interviewer Note: [If HIV negative participate reports ART drug(s), this information will be collected in Prep| Pep section]

☐ NO [*GO TO Q15.A1*] ☐ YES [*GO TO Q15.A1*] ☐ REF [*GO TO Q15.A1*]

* **Q15.A. IF NO:** Why did you decide not to take HIV-related medications?

1. Not infected with HIV [IF YES, *GO TO Q16*]	☐ NO	☐ YES	☐ REF
2. Doctor said was not necessary	☐ NO	☐ YES	☐ REF
3. Not sick	☐ NO	☐ YES	☐ REF
4. Too expensive	☐ NO	☐ YES	☐ REF
5. Don't think they work or will help	☐ NO	☐ YES	☐ REF
6. Possible side effects	☐ NO	☐ YES	☐ REF
7. 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)	☐ NO	☐ YES	☐ REF
8. Other reason	☐ NO	☐ YES	☐ REF

Q15.A1. 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? I am referring to the types of HIV drug resistance tests that are called genotyping or phenotyping.

☐ NO → ***SKIP TO Q15.B(1) IF ON HIV MEDS SINCE LAST VISIT***
SKIP TO Q16 IF NOT ON HIV MEDS SINCE LAST VISIT

☐ YES

☐ DON'T KNOW

☐ REF

Q15.A2. Has your treatment (drugs) been changed as a result of that test?

☐ NO ☐ YES ☐ DK ☐ REF

***** **Q15.B1** Since your last visit [in (MONTH, YEAR)], have you taken any medication or drug on this list?

[Show the picture list in the current March/April 2015 Positively Aware Magazine]

☐ NO [*GO TO **Q15.C1***] ☐ YES ☐ REF [*GO TO **Q15.C1***]

Q15.B2. Please name those drugs that you have taken or show me which ones.

Fill out a separate Drug Form 1 form for each reported drug taken since last visit. This drug form also contains adherence questions about the reported drug. NOTE- USE THE CADI COMPATIBLE PAPER FORMS ONLY. DO NOT USE THE SCAN FORM.

Administer DRUG Forms and Adherence questions for Abbreviated Interviews.

[*CONTINUE ADHERENCE QUESTIONS FOR ALL CURRENT DRUGS.*]

I would like to ask some Adherence questions about the anti-HIV medications you are currently taking.

Q2. When was the last time you skipped any of your medications?

- ☐ Never skip medications [*GO TO **Q4***]
- ☐ Within the past week
- ☐ 1-2 weeks ago
- ☐ 3-4 weeks ago
- ☐ 1-3 months ago
- ☐ More than 3 months ago

Q3. People miss taking their medications for various reasons. Here is a list of possible reasons. How often have you missed taking your current medications because you:

Q3.	**Never**	**Rarely**	**Sometimes**	**Often**	**Refuse**
a. Were away from home?	☐	☐	☐	☐	☐
b. Were busy with other things?	☐	☐	☐	☐	☐
c. Simply forgot?	☐	☐	☐	☐	☐
d. Had too many pills to take?	☐	☐	☐	☐	☐
e. Wanted to avoid side effects?	☐	☐	☐	☐	☐

Q3.	Never	Rarely	Sometimes	Often	Refuse
f. Did not want others to notice you taking medicatons?	☐	☐	☐	☐	☐
g. Had a change in daily routine? (e.g., vacation, holiday, non-work day)	☐	☐	☐	☐	☐
h. Felt like the drug was toxic or harmful?	☐	☐	☐	☐	☐
i. Fell asleep or slept through dose time	☐	☐	☐	☐	☐
j. Felt sick or ill?	☐	☐	☐	☐	☐
k. Felt depressed or overwhelmed?	☐	☐	☐	☐	☐
l. Had problems taking the pills?	☐	☐	☐	☐	☐
m. Ran out of pills?	☐	☐	☐	☐	☐
n. Don't want to take pills?	☐	☐	☐	☐	☐
o. Have special instructions that conflict?	☐	☐	☐	☐	☐
p. Other reason	☐	☐	☐	☐	☐
Specify other reason:					

Q4. Most anti-HIV medications need to be taken on a schedule, such as "2 times a day" or "every 8 hours". How closely did you follow your specific schedule over the last four days?

☐ Never
☐ Some of the time
☐ About half of the time
☐ Most of the time
☐ All of the time
☐ REF

Q5a. Do any of your anti-HIV medications have special instructions such as "take with food" or "take on an empty stomach" or "take with plenty of fluids"?

☐ NO [*GO TO* ***Q6***] ☐ YES ☐ REF

Q5b. How often did you follow those special instructions over the last four days?

☐ Never
☐ Some of the time
☐ About half of the time
☐ Most of the time
☐ All of the time
☐ REF

Q5c. Do any of these special instructions conflict? ☐ NO ☐ YES ☐ REF

Q6. How do you remember to take your medications?

Q6	NO	YES	REF
a. Calendar/diary	☐	☐	☐
b. Pill box	☐	☐	☐
c. Alarm	☐	☐	☐
d. Friends/family member	☐	☐	☐
e. Memory only	☐	☐	☐
f. Other	☐	☐	☐
g. Other specify:			

Q15.B3. 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 [*GO TO **Q15.C1***] ☐ YES ☐ REF [*GO TO **Q15.C1***]

IF YES: How many times did this occur? ___ ___

Did your physician prescribe or agree to any of these? ☐ NO ☐ YES ☐ REF

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

* **Q15.C1.** 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 [*GO TO **Q15.C3***] ☐ YES ☐ REF [*GO TO **Q15.C3***]

Q15.C2. Please name those drugs that you have taken.

Name:_____

Code: ____ ____ ____

Name:_____

Code: ____ ____ ____

Name:_____

Code: ____ ____ ____

If abbreviated interview, go to Q16.1A-D and Q16.11-16.15, Q25a-25b..

Q15.C3. In the past year, have you participated in any other research studies involving treatment or prevention of HIV or its complications?

☐ NO ☐ YES ☐ REF

Q15.C4. What is the name of the trial?

_____

_____

See http://www.aidsinfo.nih.gov/clinical-trials/. If not identifiable based on information from participant, obtain a medical release to get name and NCT number from his doctor.

Q15.C5. MACS CODE __ __ __ __

If no MACS code, contact CAMACS. See MACS forum - Vaccine and clinical research trials

Q16. 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)]

You are being asked about your use of the following types of medications because of their potential effects on your overall health, including your long term risks for development of illnesses such as diabetes, heart disease, and osteoporosis, as well as their potential overall effects on the health of your muscles, liver, kidneys, and your sexual functioning. Similarly, the health effects of normal aging may be impacted by the use of these medications.

Testosterone:

***Q16.1A.** Since your last visit, have you used testosterone in any of the following preparations, including *Androgel, Testim, Fortesta, Androderm (patch), Testosterone injection (Delatestryl)*?

☐ NO ☐ YES ☐ DON'T KNOW ☐ REF

[*IF NO, DON'T KNOW OR REFUSED, GO TO **Q16.12A***]

If YES:

***Q16.1B.** Was the testosterone prescribed by a health care provider? ☐ NO ☐ YES ☐ REF

***Q16.1C.** What were the reasons for using testosterone? Was it because of [Read each item]

1) Low testosterone level	☐ NO	☐ YES	☐ REF
2) Wasting or unintentional weight loss	☐ NO	☐ YES	☐ REF
3) To build muscle mass	☐ NO	☐ YES	☐ REF
4) Erectile Dysfunction	☐ NO	☐ YES	☐ REF
5) Low sexual desire	☐ NO	☐ YES	☐ REF
6) Fatigue	☐ NO	☐ YES	☐ REF
7) Anemia (low red blood cells)	☐ NO	☐ YES	☐ REF
8) To feel stronger or more energetic	☐ NO	☐ YES	☐ REF
9) Improve athletic performance	☐ NO	☐ YES	☐ REF
10) Also taking Megace (megesterol)	☐ NO	☐ YES	☐ REF
11) Other	☐ NO	☐ YES	☐ REF

If yes: specify _____

***Q16.1D.** How was it administered? Was it by [Read each item]

1) Injection	☐ NO	☐ YES	☐ REF
IF YES: Have you gotten an injection in the last 2 weeks?	☐ NO	☐ YES	☐ REF
2) Gel or patch	☐ NO	☐ YES	☐ REF
IF YES: Have you applied it in the last 24 hours?	☐ NO	☐ YES	☐ REF
3) Under skin pellet (Testopel)	☐ NO	☐ YES	☐ REF
IF YES: Have you had a pellet placed in the last 6 months?	☐ NO	☐ YES	☐ REF

Anabolic Steroids:

Q16.2A. Since your last visit [in (MONTH, YEAR)], have you taken any anabolic steroids, such as *Anadrol-50, Winstrol, Oxandrin*?

☐ NO [*GO TO **Q16.3A***]
☐ DON'T KNOW [*GO TO **Q16.3A***]
☐ YES
☐ REF [*GO TO **Q16.3A***]
☐ OTHER

Specify: _____

If YES or OTHER:

Q16.2B. What were the reasons for taking this/these steroid(s)? [Read each item]

1) Wasting or unintentional weight loss	☐ NO	☐ YES	☐ REF
2) To build muscle mass	☐ NO	☐ YES	☐ REF
3) To feel stronger or more energetic	☐ NO	☐ YES	☐ REF
4) Improve athletic performance	☐ NO	☐ YES	☐ REF
5) Other	☐ NO	☐ YES	☐ REF

If yes: specify: _____

Q16.2C. Have you taken/used the anabolic steroids in the past 5 days? ☐ NO ☐ YES ☐ REF

Glucocorticoids (corticosteroids):

Q16.3A. Thinking about medications taken in your past, have you EVER taken any steroids by mouth called glucocorticoids or corticosteroids, such as *prednisone, dexamethasone (Decadron), hydrocortisone, prednisolone (Prelone), methylprednisolone (Medrol)*?

☐ NO [*GO TO **Q16.3F***]
☐ DON'T KNOW [*GO TO **Q16.3***
☐ YES
☐ REF [*GO TO **Q16.3F***]

If YES:

Q16.3B. Approximately, how old were you when you last took any? _____ _____

Q16.3C. Have you ever taken any of these steroid pills for a period of greater than 3 months?

☐ NO ☐ YES ☐ REF

Q16.3D. Now thinking about since your last visit only, how many days in total have you taken glucocorticoid or corticosteroid pills? *(if none, fill in 0 and GO TO **Q13.3F**]*

_____ _____ _____ (up to 3 characters, must be numbers entered)

Q16.3E. What were the reasons for taking this/these steroid(s) since your last visit? *(mark all that apply)*

1)	Adrenal insufficiency	☐ NO ☐ YES ☐ REF
2)	Lung condition	☐ NO ☐ YES ☐ REF
3)	Joint condition	☐ NO ☐ YES ☐ REF
4)	Back condition	☐ NO ☐ YES ☐ REF
5)	Skin condition	☐ NO ☐ YES ☐ REF
6)	Other	☐ NO ☐ YES ☐ REF

Specify: _____

Q16.3F. Since your last visit [in (MONTH, YEAR)], have you had an injection of this/these steroid(s) into your skin or joints, back, muscle?

☐ NO ☐ YES ☐ REF

[*IF NO GLUCO MEDS SINCE LAST VISIT OR REF, GO TO **Q16.4a***]

Q16.3G. Have you taken/used the glucocorticoid(s) or corticosteroid(s) by any means in the past 5 days?

☐ NO ☐ YES ☐ REF

Q16.4A. Since your last visit [in (MONTH, YEAR)], have you taken any inhaled steroids?

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q16.5A***]

Note to interviewer: If the participant reported an inhaled medication, but is not sure whether it was a steroid, read aloud the names of the drugs listed below.

If YES:

Q16.4B. Which one(s):

Beclomethasone	☐ NO ☐ YES ☐ REF
QVAR	☐ NO ☐ YES ☐ REF

Budesonide	☐ NO ☐ YES ☐ REF
Pulmicort	☐ NO ☐ YES ☐ REF
Ciclesonide	☐ NO ☐ YES ☐ REF
Alvesco	☐ NO ☐ YES ☐ REF
Flunisolide	☐ NO ☐ YES ☐ REF
AeroBid	☐ NO ☐ YES ☐ REF
Fluticasone	☐ NO ☐ YES ☐ REF
Flovent	☐ NO ☐ YES ☐ REF
Mometasone	☐ NO ☐ YES ☐ REF
Asmanex Twisthaler	☐ NO ☐ YES ☐ REF
Triamcinolone	☐ NO ☐ YES ☐ REF
Azmacort	☐ NO ☐ YES ☐ REF
Budesonide and formoterol	☐ NO ☐ YES ☐ REF
Symbicort	☐ NO ☐ YES ☐ REF
Fluticasone and salmeterol	☐ NO ☐ YES ☐ REF
Advair	☐ NO ☐ YES ☐ REF
Mometasone and formoterol	☐ NO ☐ YES ☐ REF
Dulera	☐ NO ☐ YES ☐ REF

Q16.4C. Have you taken/used the inhaled steroid(s) in the past 5 days? ☐ NO ☐ YES ☐ REF

Q16.5A. Since your last visit [in (MONTH, YEAR)], have you taken thyroid hormones, such as *Synthroid, Levoxyl, levothyroxine, or Cytomel*?

☐ YES
☐ NO [*GO TO* ***Q16.6A***]
☐ OTHER
Specify: _____
☐ REF [*GO TO* ***Q16.6A***]
☐ DON'T KNOW [*GO TO* ***Q16.6A***]

Q16.5B. Have you taken/used thyroid hormone(s) in the past 5 days? ☐ NO ☐ YES ☐ REF

Q16. Continued	**a.** How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	**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)?
6. Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
7. Tranquilizers or sleeping pills	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
8. Antidepressants or mood elevators	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
9. Acyclovir, famciclovir or valacyclovir for herpes (zovirax, famvir, valtres) **IF YES**, did you take it: Everyday ☐ **NO** ☐ **YES** Only when you had active lesions or outbreak? ☐ **NO** ☐ **YES**	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
10. Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
***11.** Aspirin taken three days or more on a weekly basis	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
***12.** Medications to lower cholesterol, triglycerides, lipids or blood fat __ __ __ __ __ __ __ __ __ __ __ __	☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES**	_____ _____ _____ _____ _____ _____	☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES**
***13.** Medications to treat hypertension __ __ __ __ __ __ __ __	☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES**	_____ _____ _____ _____	☐ **NO** ☐ **YES** ☐ **NO** ☐ **YES**

Q16. Continued	**a.** How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	**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**	_____ _____	☐ **NO** ☐ **YES**
__ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
__ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
***14.** Medications to treat diabetes __ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
__ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
__ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
***15.** Medications to treat hepatitis __ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**
__ __ __ __	☐ **NO** ☐ **YES**	_____ _____	☐ **NO** ☐ **YES**

a) Have you (taken/used) Any other medications since your last visit [in (MONTH, YEAR)]?	**(b)** When specified, what was the name of the (KIND OF DRUG) you took?	**(c)** What did you take this drug for?	**(d)** Have you taken/used any in the past 5 days?
16. Other **a. ☐ NO ☐ YES**	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
b. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
c. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
d. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
e. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
f. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**
g. ☐ NO ☐ YES	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	**☐ NO ☐ YES**

a) Have you (taken/used) Any other medications since your last visit [in (MONTH, YEAR)]?	(b) When specified, what was the name of the (KIND OF DRUG) you took?	(c) What did you take this drug for?	(d) Have you taken/used any in the past 5 days?
h. ☐ **NO** ☐ **YES**	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	☐ **NO** ☐ **YES**
i. ☐ **NO** ☐ **YES**	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	☐ **NO** ☐ **YES**
j. ☐ **NO** ☐ **YES**	Name and code of drug**:** __ __ __ _____	Use of drug: _____ _____ _____ _____	☐ **NO** ☐ **YES**

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

Q17.A. Since your last visit **[in (MONTH, YEAR)]**, have you received assistance from ADAP (AIDS Drug Assistance Program)?

☐ NO ☐ YES ☐ REF

Q17.B. Since your last visit **[in (MONTH, YEAR)]**, have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

☐ NO [*GO TO **Q17.C***]

☐ YES - did you have: [*GO TO **Q17.B1***]

☐ REF

1) Coverage by an HMO ☐ NO ☐ YES

2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) ☐ NO ☐ YES

3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) ☐ NO ☐ YES

4) Medicaid, Medi-Cal, or Medical Assistance ☐ NO ☐ YES

5) Medicare (for people over 65 or permanently disabled)	☐ NO	☐ YES
6) Health care benefits for The Armed Forces or Veteran's Administration, **TRICARE**, **CHAMPUS** or **CHAMP-VA** medical insurance for dependents of military personnel or survivors of disabled veterans.	☐ NO	☐ YES
7) Ryan White	☐ NO	☐ YES
8) Other	☐ NO	☐ YES

Specify Other:

Q17.C. Did you have insurance coverage that pays for any of your medications?

☐ NO ☐ YES ☐ DK ☐ REF

[*IF **Q17.C** AND **Q17.B** = NO, GO TO **Q19**. IF **Q17.C** OR **Q17.B** = YES, GO TO **Q18***]

Q18. Are you currently insured? ☐ NO ☐ YES ☐ REF

Q19. Did you have any type of dental insurance coverage at any time since your last visit **[MONTH, YEAR]**?

☐ NO ☐ YES ☐ REF

Q20. 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.]**

Please include all doctor visits and any other outpatient visits or services for each of your reported illness, and any additional illness.

Source for Medical Care	Have you used…	How many times?
1) Doctor's office or any other clinic, including specialty clinic and Urgent Care	☐ NO ☐ YES	____ ____
2) Emergency Room	☐ NO ☐ YES	____ ____
3) Other outpatient service: facilities providing lab work, imaging, or non-mental health	☐ NO ☐ YES	____ ____
Specify Other:		

Q21.A. Since your last visit **[in (MONTH, YEAR)]**, have you seen a dental health care provider, such as a dentist or dental hygienist?

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q21.C**. IF YES, GO TO **Q21.B***]

Q21.B. How many times? ___ _____

Q22.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 ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q23.A**. IF YES, GO TO **Q22.B***]

Q22.B. IF YES: Why did you not seek care or obtain prescription medications?
[READ EACH AND MARK ALL THAT APPLY]

Financial reasons: ☐ NO ☐ YES ☐ REF

Other non-financial reasons: ☐ NO ☐ YES ☐ REF

Specify Other: _____

_____

Q23.A. Is there anything more that I haven't asked that you think we should know?

☐ NO, nothing more → **THANK PARTICIPANT AND GO TO ITEM 24**

☐ YES

Q23.B. Tell me about it. ***RECORD FULLY IN R'S OWN WORDS***

TEXT BOX for THINGS TO KNOW:

Q24. Administration of Behavior Section ***"[If the participant does not complete the MWII (ACASI), administer the CADI paper version of the behavior section and scannable paper versions of the full QOL and S2/S3.Depression and social support scales]"***

☐ CADI Interview

☐ MWII (ACASI)

☐ Participant Refused behavior section

*__Q25a.__ Telephone interview? ☐ NO ☐ YES

*__Q25b.__ Limited visit? ☐ NO ☐ YES

*__Q26.__ Home visit? ☐ NO ☐ YES

If abbreviated interview, administer smoking session (Q33a1 – Q33G) before ending questionnaire.

Q27. Interview Method

☐ Interview conducted on a paper form then entered into CADI

Q27.a. Abbreviated interview? ☐ NO ☐ YES

Q28. DATE INTERVIEW WAS COMPLETED: ___ ___/___ ___/ ___ ___ ___ ___ (*MM/DD/YYYY*)

IF BEHAVIOR SECTION IS ADMINISTERED BY FORM, GO TO Q29 AND FILL IN TIME ENDED AFTER THE COMPLETION OF THE PREP & THE BEHAVIOR SECTION.

Q29. Time ended: Hours ___ ___

Minutes ___ ___

AM/PM ____

Interviewers name:

Last name _____

First Name _____

INTERVIEWER'S NUMBER ___ ___ ___

Choose clinic:

☐ BA Share Clinic
☐ BA Whitman Walker
☐ CH Howard Brown
☐ CH Northwestern
☐ CH CORE
☐ PI
☐ PI (Ohio)
☐ LA Wilshire
☐ LA LAGLC
☐ LA Harbor
☐ LA Satellite Clinic

I have a few more questions regarding Anti-HIV Medications (PREP or PEP) Questions.
It has been reported that some people NOT infected with HIV take anti HIV medications to try to prevent getting HIV when having sex.

Q1. Have you ever taken medications **AFTER** a possible exposure to HIV (such as condomless sex or a needlestick injury)in order to prevent yourself from becoming infected with HIV (also called post exposure prophylaxis or PEP)?

☐ NO
☐ YES
☐ **HIV infected** (Not applicable)
☐ REF

[*IF NO OR IF HIV INFECTED OR REF, THEN GO TO **Q2***]

Q1a. How many times have you used preventative HIV medications **AFTER** a possible exposure in order to prevent HIV (post exposure prophylaxis or PEP) in your lifetime? _____

Q1b. In the past 6 months, how many times have you used preventative HIV medications **AFTER** a possible exposure in order to prevent HIV (post exposure prophylaxis or PEP)? _____

Q1c. What were the reason(s) for taking HIV medications **AFTER** possible exposure to HIV (PEP or post exposure prophylaxis) in order prevent yourself from getting HIV? (Please select all that apply)

A. Condomless insertive anal sex with a partner of unknown HIV status
B. Condomless receptive anal sex with a partner of unknown HIV status
C. Condomless insertive anal sex with an HIV positive partner
D. Condomless receptive anal sex with an HIV positive partner
E. Condomless vaginal sex with a partner of unknown serostatus
F. Condomless vaginal sex with an HIV positive partner
G. Contact with blood or other potentially infectious material in a health care or work place setting (occupational exposure)
H. Injection drug use
I. Other

Q1d. In the past six months, what medications did you take **AFTER** the high risk exposure to prevent yourself from getting HIV (as PEP or post exposure prophylaxis)? (Select all that apply)

- ☐ Combivir (AZT and lamivudine)
- ☐ Truvada (Tenofovir/emtricitabine)
- ☐ Descovy (Tenofovir alafenamide/emtricitabine)
- ☐ Stribild (Tenofovir/ emtricitabine/ cobicistat/ elvitegravir)
- ☐ Triumeq (Abacavir/lamivudine/dolutegravir)
- ☐ Epzicom (Abacavir/lamivudine)
- ☐ Atripla (Emtricitabine/tenofovir/efavirenz)
- ☐ Complera (Emtricitabine/tenofovir/rilpivirine)
- ☐ Kaletra (lopinavir/ritonavir)
- ☐ Isentress (raltegravir)
- ☐ Selzentry (maraviroc)
- ☐ Tivicay (dolutegravir)
- ☐ Prezista (darunavir)
- ☐ Reyataz (atazanavir)
- ☐ Norvir (ritonavir)
- ☐ Other prescribed
- ☐ None

Q2. Have you ever taken medications to prevent yourself from becoming HIV –infected **BEFORE** engaging in activities that you thought might put you at risk (PrEP or pre-exposure prophylaxis)?

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q31.a.***]

Q2a. In the past six months have you taken medications to prevent becoming HIV-infected (PrEP or pre-exposure prophylaxis) **BEFORE** engaging in activities that put you at risk for HIV or because you thought you might engage in such activities?

☐ NO ☐ YES ☐ REF

[*IF NO OR REF, GO TO **Q31.a.***]

Q2b. What medications have you taken to prevent becoming HIV-infected (PrEP or pre-exposure prophylaxis) **BEFORE** engaging in activities that put you at risk for HIV or because you thought you might engage in such activities?

- ☐ Truvada (Tenofovir/emtricitabine)
- ☐ Descovy (Tenofovir alafenamide/emtricitabine)
- ☐ Selzentry (maraviroc)
- ☐ Rilpivirine
- ☐ Other prescribed

Q3. In the last six months, how consistently did you take medications to prevent HIV infection **BEFORE** engaging in activities that might put you at risk for HIV?

- ☐ Daily or almost daily
- ☐ Once or twice per week
- ☐ Less than weekly
- ☐ Periodically or intermittently
- ☐ Other
- ☐ REF

Q4. If you stopped using medication to prevent HIV infection (PrEP or pre-exposure prophylaxis) over the past 6 month months, why did you stop using it?

A. Side effects
B. Too expensive
C. Difficulty finding a doctor to prescribe
D. No longer engaged in sexual relationships or other behaviors that put me at risk
E. Using PrEP periodically or intermittently
F. I forgot to take it
G. Other

Q5. Where did you obtain medications to prevent HIV infection to be taken **BEFORE** engaging in activities that might put you at risk for HIV infection?

A. Prescribed by a doctor or other health care provider
B. As part of a clinical research study
C. From a sexual partner
D. From some other non-medical source
E. Other

Q6. What were the reason(s) for taking HIV medications **BEFORE** possible exposure to HIV (PEP or post exposure prophylaxis) in order prevent yourself from getting HIV? (Please select all that apply)

A. Condomless insertive anal sex with a partner of unknown HIV status
B. Condomless receptive anal sex with a partner of unknown HIV status
C. Condomless insertive anal sex with an HIV positive partner
D. Condomless receptive anal sex with an HIV positive partner
E. Condomless vaginal sex with a partner of unknown serostatus
F. Condomless vaginal sex with an HIV positive partner
G. Contact with blood or other potentially infectious material in a health care or work place setting (occupational exposure)
H. Injection drug use
I. Other

Q7. Which statement best describes your use of condoms for anal sex while you were taking PrEP?

A. I have used condoms less often than I did before starting PrEP
B. I have used condoms more often than I did before I started PrEP
C. I have stopped using condoms since I started PrEP
D. I have used condoms infrequently
E. There has been no change in my condom usage

Q8. While taking medication to prevent HIV infection (PrEP or pre-exposure prophylaxis), has the number of sexual partners you have had

A. Increased
B. Decreased
C. Stayed the same

Q31.a. At present, which of the following categories describes your annual individual gross income before taxes?

☐ 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-$99,999
☐ $100,000-$149,999
☐ $150,000 or more
☐ Do not wish to answer

Q31.b. What was the highest grade or level of regular school or college that you finished and got credit for? Choose the answer that best describes the last year of school you completed.

☐ 8th grade (or less)
☐ 9th, 10th, or 11th grade
☐ 12th grade (high school graduate or a GED)
☐ At least one year of college but no degree
☐ Two years of college and got a degree
☐ Four years of college and got a degree
☐ Some graduate school
☐ A graduate program and got a post-graduate degree

Q31.c What is your current employment status? (*Please select all that apply to you*.)

☐ Working full-time (35 hours or more per week)
☐ Working part-time (less than 35 hours per week)
☐ Unemployed but seeking work
☐ Unemployed, not seeking work
☐ Student (either full-time or part-time)
☐ Retired
☐ Disability

Q31.d Are you self-employed? ☐ NO ☐ YES ☐ REF

Q31.e. Are you experiencing major financial difficulty meeting your basic expenses?

☐ NO ☐ YES ☐ REF

*[IF NO OR REF, GO TO **Q32**]*

Q31.f. Is the difficulty less, the same, or greater than at your last visit in [MONTH, YEAR]?

☐ Less ☐ Same ☐ Greater ☐ REF

Q32. Since your last visit in [MONTH, YEAR], has your employment status changed for any reason?

☐ NO ☐ YES ☐ REF

[*IF YES, GO TO **Q32.A**. IF NO OR REF, GO TO **Q33.A1***]

Q32.a. What were the reasons? (Please select all that apply to you.)

- ☐ Became too sick to work
- ☐ Early retirement
- ☐ Changed job as a personal decision
- ☐ Other

Specify: _____

The following is a series of questions about specific behaviors, including cigarette smoking, alcohol use, sexual activities, and recreational drug use.

NOTE - Administer the smoking session if this is an abbreviated interview. Then end interview.

***Q33.A1.** Have you ever smoked cigarettes?

☐ NO [*GO TO **Q33.d***] ☐ YES [*GO TO **Q33.A2***] ☐ REF [*GO TO **Q33.d***]

Q33.A2. Thinking about the entire time you have smoked cigarettes, what percentage of that time did you smoke menthol cigarettes?

- ☐ 100–75% of the time
- ☐ Less than 75% but greater than 25% of the time
- ☐ Less than 25% of the time
- ☐ REF

Q33.B. Do you smoke cigarettes now (as of 1 month ago)?

☐ NO [***GO TO** **Q33.d***]

☐ YES [***GO TO Q33.c***]

☐ Occasionally (less than one cigarette per day) [***GO TO Q33.d***]

☐ REF [***GO TO Q33.d***]

Q33.C. How many packs do you usually smoke per day?

☐ Less than ½ pack

☐ At least ½ pack; but less than 1 pack per day

☐ At least 1 but less than 2 packs

☐ 2 or more packs per day

☐ REF

Q33.D. Since your last visit, [in MONTH, YEAR], have you smoked E-cigarettes?

☐ NO ☐ YES ☐ Occasionally (less than one cigarette per day) ☐ REF

Q33.E. Are you smoking them now?

☐ NO ☐ YES ☐ Occasionally ☐ REF

Q33.F. Since your last visit [in MONTH YEAR], have you used any stop-smoking medications, such as patch, gum, nasal spray, inhalers, or lozenges?

☐ NO ☐ YES ☐ Occasionally ☐ REF

Q33.G. Since your last visit [in MONTH, YEAR], how many months have you lived in a household with at least one cigarette smoker other than yourself?

Please think about multiple households in which you lived.

__ __ __ months (up to 3 characters, must be numbers entered)

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. Check the box next to the one best answer for each question.

Q34.A. How often have you had drinks containing alcohol?

☐ Never [*GO TO Q35.1*]

☐ Less than monthly

☐ Monthly

☐ Weekly

☐ Daily or almost daily

☐ REF [*GO TO Q35.1*]

Q34.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 ½ ounces of 80-proof hard liquor.)

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

Q34.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 ½ ounces of 80-proof hard liquor.)

- ☐ Never
- ☐ Less than monthly
- ☐ Monthly
- ☐ Weekly
- ☐ Daily or almost daily
- ☐ REF

The questions below are about how much difficulty, if any, you have doing certain activities because of your vision. If you usually wear eyeglasses or contact lenses to do these activities, please rate your ability to do them while wearing glasses or contact.

Q35.1. How much difficulty do you have reading print in newspapers or other similar printed material?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Q35.2. How much difficulty do you have doing work or hobbies that require you to see well up close such as cooking, sewing, fixing things around the house, or using hand tools?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Q35.3. How much difficulty do you have going up steps, stairs, or curbs in dim light or at night?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Q35.4. How much difficulty do you have noticing objects off to the side while you are walking?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Q35.5. How much difficulty do you have finding something on a crowded shelf?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Q35.6. How much difficulty do you have driving in the daytime in familiar places?

A. No difficulty

B. A little difficulty

C. Moderate difficulty

D. Extreme difficulty

E. Unable to do because of eyesight

F. Does not do this for other reasons

G. Don't know

H. Refused

Now you will be asked some questions about your sexual activity. We realize that this is a very personal subject. Your answers will be completely confidential.

Q37.A. How many different women (if any) have you had sexual intercourse with since your last visit [in MONTH, YEAR]?

___ ___ ___ (up to 3 characters, must be numbers entered)

☐ REF

Q37.B. With how many (other) women have you had sexual activity that did not include intercourse since your last visit [in MONTH, YEAR]?

___ ___ ___ (up to 3 characters, must be numbers entered)

☐ REF

IF 0 PARTNERS (Q37.A + Q37.B = 0), GO TO Q40.a

Q37.B.1. How many of your female sexual partners, if any, have you met since your last visit?

Q37.B.1 should be <= to Q37.A. + Q37.B.

___ ___ ___ (up to 3 characters, must be numbers entered)

☐ REF

IF ONLY 1 PARTNER (Q37.A + Q37.B = 1), GO TO Q37.C1	IF MORE THAN 1 PARTNER (Q37.A + Q37.B ≥ 2), GO TO Q38

Q37.C1. You said you had intercourse or sexual activity with only one woman since your last visit [in MONTH, YEAR]. How would you describe this woman?

☐ Main partner or someone you have a longstanding relationship with, live with, or partner with.

☐ Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with.

☐ Exchange partner: Someone you exchanged money or drugs with for sex

☐ REF

The next questions are about different kinds of sexual activity some men engage in with women.

Only one woman with NO intercourse, go to column a - 38.2a.
Only one woman with intercourse), go to column a - 38.1a.

Two or more women with NO intercourse, go to column b - 38.2b.
Two or more women with intercourse), go to column b - 38.1b.

Q38. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.		
	a.	**b.**
1.	Since your last visit [in MONTH, YEAR], did you have unprotected vaginal or anal intercourse (did not use a condom) with this partner? ☐ NO ☐ YES ☐ REF	1.) Since your last visit [in MONTH, YEAR], with how many of these women did you have unprotected vaginal or anal intercourse (did not use a condom)? — — — 2.) How many of these partners were: a. HIV negative ___ b. HIV positive ___ c. You are unsure about? ___
2.	Since your last visit [in MONTH, YEAR], did you use your tongue to touch or lick her genitals (vagina, clitoris)? ☐ NO ☐ YES ☐ REF	1.) Since your last visit [in MONTH, YEAR], with how many of these women did you use your tongue to touch or lick her genitals (vagina, clitoris)?

Q38. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.		
	a.	**b.**
		__ __ __ 2.) How many of these partners were: a. HIV negative ___ b. HIV positive ___ c. You are unsure about? ___
3.	What is the HIV status of this partner? ☐ NEGATIVE ☐ POSITIVE ☐ DON'T KNOW **[GO TO Q.40.a.]**	

Q40.a. How many different men (if any) have you had sexual intercourse with since your last visit [in MONTH, YEAR]?

__ __ __ (up to 3 characters, must be numbers entered)

☐ REF

Q40.b. With how many (other) men have you had sexual activity that did not include intercourse since your last visit [in MONTH, YEAR]?

__ __ __ (up to 3 characters, must be numbers entered)

☐ REF

IF 0 PARTNERS (Q40.a + Q40.b = 0), GO TO Q42.1.b.

Q40c. How many of your male sexual partners, if any, have you met since your last visit?

__ __ __ (up to 3 characters, must be numbers entered)

☐ REF

Q40c. must be <= (Q40a. + Q40b)

IF ONLY 1 PARTNER (Q40.a + Q40.b = 1), GO TO Q40.c1

IF MORE THAN 1 PARTNER (Q40.a + Q40.b ≥ 2), GO TO Q41

Q40.c1. You said you had intercourse or sexual activity with only one man since your last visit [in MONTH, YEAR]. How would you describe this man?

☐ Main partner or someone you have a longstanding relationship with, live with, or partner with.

☐ Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with.

☐ Exchange partner: Someone you exchanged money or drugs with for sex

☐ REF

The next questions are about different kinds of sexual activity some men engage in with other men.
IF NO INTERCOURSE WITH MEN, SKIP TO Q42.1.b (drug section)

Only one man with NO intercourse, go to column a - Q41.3a
Two or more men with NO intercourse, go to column a - Q41.3b.

Only one man with intercourse, go to column b - Q41.1a
Two or more men with intercourse go to column b -Q41.1b

	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
1.	Since your last visit [in MONTH, YEAR] did you have unprotected INSERTIVE anal intercourse with this partner (put your penis in his anus or butt without a condom)? ☐ NO ☐ YES ☐ REF	1.) Since your last visit [in MONTH, YEAR], with how many men did you have unprotected INSERTIVE anal intercourse (put your penis in their anus or butt without a condom)? ***** Q41.1.b must be <= Q40.a***** __ __ __ (up to 3 characters, must be numbers entered) 2.) How many of these partners were: a. HIV negative ___ b. HIV positive ___ c. You are unsure about? ___

	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
2.	Since your last visit [in MONTH, YEAR], did you have unprotected RECEPTIVE anal intercourse with this main partner (put his penis in your anus or butt without a condom)? ☐ NO ☐ YES ☐ REF	1.) Since your last visit [in MONTH, YEAR], with how many men you have unprotected RECEPTIVE anal intercourse (put their penis in your anus or butt without a condom)? ***** Q41.2.b must be <= Q40.a***** __ __ __ (up to 3 characters, must be numbers entered) 2.) How many of these partners were: a. HIV negative ___ b. HIV positive ___ c. You are unsure about? ___
3.	Since your last visit [in MONTH, YEAR], did this man put his penis in your mouth? ☐ NO ☐ YES ☐ REF	
4.	Since your last visit [in MONTH, YEAR], did you put your penis in this man's mouth? ☐ NO ☐ YES ☐ REF	Since your last visit [in (MONTH, YEAR)], how many men put their penis in your mouth? ***** Q41.4.b must be <= Q40.a + Q40.b***** _ __ __ (up to 3 characters, must be numbers entered)
5.	What is the HIV status of this partner? ☐ NEGATIVE ☐ POSITIVE ☐ DON'T KNOW **[GO TO Q.42.1b. (drug section)**	Since your last visit [in (MONTH, YEAR)], with how many men did you put your penis in their mouth? ***** Q41.5.b must be <= Q40.a + Q40.b***** _ __ __ (up to 3 characters, must be numbers entered)

The next series of questions are related to recreational or street drugs you may have used since your last visit [in MONTH, YEAR].

Q42.1b. How often did you use or take pot, marijuana or hash since your last visit [in MONTH, YEAR]?

☐ Daily ☐ Monthly
☐ Weekly ☐ Less often
☐ Never ☐ REF

Q42.1c. What were the reasons for using pot? Select all that apply.

- ☐ For medical reasons
- ☐ For recreational reasons, not including sex
- ☐ For sexual enhancement reasons
- ☐ To increase ability to socialize
- ☐ To fit in with a group

Q42.2b. How often did you use or take "poppers" like nitrate inhalants (amyl, butyl, or isopropyl nitrites) since your last visit [in MONTH, YEAR]?

- ☐ Daily
- ☐ Weekly
- ☐ Never
- ☐ Monthly
- ☐ Less often
- ☐ REF

Q42.3b. How often did you use or take crack or cocaine that you smoked since your last visit [in MONTH, YEAR]?

- ☐ Daily
- ☐ Weekly
- ☐ Never
- ☐ Monthly
- ☐ Less often
- ☐ REF

Q42.4b. How often did you use or take other forms of cocaine since your last visit [in MONTH, YEAR]?

- ☐ Daily
- ☐ Weekly
- ☐ Never [GO TO Q42.5.a.]
- ☐ Monthly
- ☐ Less often
- ☐ REF

Q42.4c.) How did you use or take other forms of cocaine since your last visit [in MONTH, YEAR]? (Select all that apply).

- ☐ Snorted
- ☐ Swallowed
- ☐ Put in anus ("booty bumped")
- ☐ Injected (intravenous use)

Q42.5b. How often did you use or take speed, meth or ice since your last visit [in MONTH, YEAR]?

- ☐ Daily
- ☐ Weekly
- ☐ Never [go to Q42.6.a.]
- ☐ Monthly
- ☐ Less often
- ☐ REF

Q42.5c. How did you use or take speed, meth or ice since your last visit [in MONTH, YEAR]? (Select all that apply).

- ☐ Snorted
- ☐ Swallowed

☐ Smoked ☐ Injected (intravenous use)

☐ Put in anus ("booty bumped")

Q42.6a. Have you taken or used any heroin since your last visit [in MONTH, YEAR]?

☐ NO [*IF NO, GO TO **Q42.7a***] ☐ YES [*IF YES, GO TO **Q42.6b***] ☐ REF [*IF REF, GO TO **Q42.7a***]

Q42.6b. How often did you use or take heroin since your last visit [in MONTH, YEAR]?

☐ Daily ☐ Monthly

☐ Weekly ☐ Less often

Q42.6c. How did you use or take heroin since your last visit [in MONTH, YEAR]? (Select all that apply.)

☐ Snorted ☐ Put in anus ("booty bumped")

☐ Swallowed ☐ Injected (intravenous use)

☐ Smoked

Q42.7a. Have you taken or used any speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]?

☐ NO [*IF NO, GO TO **Q42.9a***] ☐ YES [*IF YES, GO TO **Q42.7b***] ☐ REF [*IF REF, GO TO **Q42.9a***]

Q42.7b. How often did you use or take speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]?

☐ Daily ☐ Monthly

☐ Weekly ☐ Less often

Q42.7c. How did you use or take speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]? (Select all that apply).

☐ Snorted ☐ Put in anus ("booty bumped")

☐ Swallowed ☐ Injected (intravenous use)

☐ Smoked

Q42.9a) Have you taken or used any sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction since your last visit [in MONTH, YEAR]?

☐ NO [*IF NO, GO TO **Q42.10a***] ☐ YES [*IF YES, GO TO **Q42.9b***] ☐ REF [*IF REF, GO TO **Q42.10a***]

Definition: Sexual performance enhancing drugs include Viagra, Herbal Viagra, Levitra, Cialis, Testosterone patch, injection or topical creams, Yohimbine, Ephedrine or Guarana containing products, Tri-Mix, Penile suppositories, or any other compound, herbal preparation or prescription drug used primarily to enhance sexual performance in the absence of diagnosed primary erectile dysfunction.

Q42.9b. How often did you use or take sexual performance enhancing drugs **other than those prescribed by a medical provider** for diagnosed erectile dysfunction since your last visit [in MONTH, YEAR]?

☐ Daily ☐ Monthly

☐ Weekly ☐ Less often

Q42.10b. Please select all the other kinds of street or club drugs that you have taken or used since your last visit and how often you have used them since your last visit [in MONTH, YEAR]. This is for non-prescription drugs only.

☐ "Downers" including barbiturates, yellow jackets or reds, tranquilizers like Valium, Librium, Xanax or other sedatives or hypnotics like Quaaludes.

☐ Methadone or other opiates or narcotics like Demerol

☐ PCP, angel dust, psychedelics, hallucinogens, LSD, DMT, mescaline, Ketamine or special K

☐ Ethyl Chloride as an inhalant

☐ GHB

☐ Other

☐ None [**GO TO Q43.**]

☐ REF [**GO TO Q43.**]

Q42.10c. **Which street drugs did you take and how often.** How often did you use or take street or club drugs since your last visit [in MONTH, YEAR]**?**

	Daily	**Weekly**	**Monthly**	**Less Often**
"Downers" including barbiturates, yellow jackets or reds, tranquilizers like Valium, Librium, Xanax or other sedatives or hypnotics like Quaaludes.	☐	☐	☐	☐
Methadone or other opiates or narcotics like Demerol	☐	☐	☐	☐
PCP, angel dust, psychedelics, hallucinogens, LSD, DMT, mescaline, Ketamine or special K	☐	☐	☐	☐
Ethyl Chloride as an inhalant	☐	☐	☐	☐
GHB	☐	☐	☐	☐
Other, specify: _____	☐	☐	☐	☐

[*IF NO INJECTING DRUG USE, GO TO **Q45***]

END CADI