PWA SHORT TELEPHONE INTERVIEW

) #:___ ___ ___ ___ ___ DATE: ____/____/____

Contact established, but participant unable or unwilling to complete the questionnaire ○Yes ○No VISIT #: _____.7

1. **Has your address changed since your last contact with us?** ○Yes ○No

_____

_____

2. **Have you had any serious illness(es) or significant symptoms since your last contact with us? IF YES, briefly describe all illnesses below. Details are especially helpful on any AIDS diagnoses, cancer or any neurologic conditions.**

Illness/Symptoms	Mo	Day	Yr	ICD-9

3. **At any time (since your last visit in [Month]) did you stay overnight as a patient in a hospital?** ○Yes ○No

4. **Name and address of the doctor and/or hospital that we may contact for further information: (Any information that you provide will be helpful).**

Dr. Name:	Telephone:
Address:	City:
Hospital/address:	City:
Admission Dates:	

5. **Do you have any kind of health insurance coverage or Medical Assistance?** ○Yes ○No

(a) Coverage by an HMO	Yes	No
(b) Private Insurance (Blue Cross, CIGNA, etc)(not as an HMO)	Yes	No
(c) Individual private insurance (Blue Cross, CIGNA, etc.)(not as an HMO)	Yes	No
(d) Medicaid, Medi-Cal or Medical Assistance	Yes	No
(e) Medicare (for people over 65 or permanently disabled)	Yes	No
(f) Health care benefits for the Armed Forces or Veteran's Administration	Yes	No
(g) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors or disabled veterans	Yes	No
(h) Other:	Yes	No

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

HMO		Doctor's Office (non-HMO)	
v Clinic		Emergency Room	
ıer outpatient (specify):			
No regular source or medical care		Don't know	

7. Are you taking any of the following drugs to help fight AIDS or HIV infection?

AZT	Yes	No	Fluconazole	Yes	No
ddI	Yes	No	Ketoconazole	Yes	No
ddC	Yes	No	Bactrim	Yes	No
Clarithromycin	Yes	No	Rifabutin	Yes	No
Dapsone	Yes	No	Pentamidine	Yes	No
Epogen (Erythropoietin)	Yes	No	Ganciclovir	Yes	No
ACV Zovirax	Yes	No	Neupogen (G-CSF)	Yes	No

8. Please name any other drugs or substances that you are taking to help fight, prevent, or treat any HIV-related conditions.

_____

_____

9. What is your employment status?

Working full-time (35 hours or more per week)		Working part-time (less than 35 hours per week)	
Unemployed		Disabled	

10. As usual, we are asking for the names and phone numbers of two contacts who do not live with you but would always know your whereabouts.

Contact #1

_____

_____ Phone# ( ) _____

Contact #2

_____

_____ Phone# ( ) _____

We will be sending you a medical records release form to sign. It is especially important to have a current one for our ɔipants who have experienced and recent illness. I hope you will return it to us as soon as it is possible. Thank you.

THANK YOU FOR COMPLETING THIS FORM