NEW ENROLLMENT BASELINE SECTION 4

MARKING INSTRUCTIONS

- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make **NO** stray marks.
- **DO NOT** fold this form.

CORRECT MARK ● INCORRECT MARKS ✓ ✗ ⬭ ⊙

ID NUMBER	VISIT NO.	TIME BEGAN	DATE
	365	HR: MIN: AM PM	MONTH: Jan, Feb, Mar, Apr, May, June, July, Aug, Sept, Oct, Nov, Dec; DAY: 0; YEAR: 01, 02

INTERVIEW INTRODUCTION

First, I'm going to ask you about your health history. I'll be reading you a series of questions about diseases, symptoms, and medicines you may have had in the past. At the beginning of each section, I'll read a question to you; if anything I ask you is unclear, please stop me and I will try to make the question clearer.

I understand that some of these questions may be difficult for you to answer and dates may be hard to remember exactly. Please take as much time as you need so that I may collect information which is as accurate as possible.

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.

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PLEASE DO NOT WRITE IN THIS AREA

SERIAL #

1. **Since we last saw you, have you been ill?**

○ No → **SKIP TO Q 2**

○ Yes

Let's start with a list of medical conditions. You may not have heard of some of them because they are rare, but if you've had any of them, you'll know it. [Since we last saw you in (MONTH)] Has a doctor or medical provider, such as a nurse or physician's assistant, told you that you had any of the following? How about (EACH)?

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it first diagnosed?
A. Kaposi's Sarcoma or KS	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
B. Pneumocystis carinii pneumonia (PCP)	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
C. Other pneumonia or lung infections other than bronchitis	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
D. Toxoplasmosis or Toxo Infection	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it? CODE ALL THAT APPLY. **(DO NOT CODE "YES" IF ONLY CMV ANTIBODIES.)** ○ Eyes ○ Lung ○ Colon ○ Other (not blood) Specify:	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
F. MAI, MAC or Mycobacterial infection	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
G. Lymphoma, specify ○ Primary brain lymphoma ○ Non-Hodgkin's ○ Other Specify:	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
H. Meningitis related to HIV or Cryptococcal Meningitis	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
I. Cryptococcal Infection without Meningitis	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02
J. Candida or thrush, a yeast infection of the esophagus (the tube between your mouth and stomach)	NO ○ GO TO NEXT ROW YES ○	J F M A M J J A S O N D 01 02

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1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it first diagnosed?
K. Cryptosporidiosis	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
L. Wasting syndrome or severe weight loss	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
M. Herpes Simplex Infection of the lungs or esophagus (the tube between your mouth and stomach)	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
N. Histoplasmosis Infection or Histo	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
O. Cocci, Coccidioidomycosis infection or valley fever	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
P. Dementia or Encephalopathy or a memory problem or confusion caused by HIV	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
Q. Infection in the blood with a bacterium called Salmonella	NO ○ GO TO NEXT ROW YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)
R. PML, Progressive Multifocal Leukoencephalopathy, a disease of the brain	NO ○ GO TO Q 2 YES ○	(J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (01) (02)

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

Name of hospital/clinic or doctor

Address

City State

2. The next few questions are about Tuberculosis, or TB for short. To see if a person has tuberculosis a doctor or nurse will give a skin test—sometimes called a PPD test. If the skin test shows the person has been exposed or infected with tuberculosis, more tests are done to see if they are sick from the tuberculosis. A person might get an X-ray or be asked to cough into a machine. If they are sick, we say they have "tuberculosis disease". Sometimes this is called "active" or "infectious tuberculosis". Usually, if a person has tuberculosis disease, people who live or work with the person will be tested for tuberculosis too.

	NO	YES
A. Have you ever had a skin test for TB, sometimes called a PPD?	○ SKIP TO Q 3	○
B. IF YES: When was your last test? (J) (F) (M) (A) (M) (J) (J) (A) (S) (O) (N) (D) (91) (92) (93) (94) (95) (96) (97) (98) (99) (00) (01) (02)		
C. Was it positive?	○	○

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3. A. [Since we last saw you in (MONTH)] Have you had an active TB infection? NO ○ YES ○ SKIP TO Q 4

B. Was the TB in your lungs? ○ ○

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

4. [Since we last saw you in (MONTH)] In addition to these diagnoses, has a doctor or other medical provider told you that you had AIDS? NO ○ YES ○

5. Has a doctor or other medical provider ever told you that you had any cancer (other than Kaposi's Sarcoma, primary brain lymphoma, or non-Hodgkin's lymphoma)?

○ No → IF "NO," GO TO Q 6

○ Yes

a IF YES: What kind of cancer?		b In what month and year was it first diagnosed?
1) Site / Type	0 1M 2M 3M 4M 5M 6M 7M 8M 9M 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02
2) Site / Type	0 1M 2M 3M 4M 5M 6M 7M 8M 9M 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	J F M A M J J A S O N D 91 92 93 94 95 96 97 98 99 00 01 02

c What was the name and address of the physician who diagnosed the cancer?

1)

Name of hospital/clinic or doctor

Address

City State

2)

Name of hospital/clinic or doctor

Address

City State

6. Have you ever had an organ transplant? NO ○ YES ○

7. Have you had any radiation treatment in the last 20 years, other than x-rays by the dentist or to diagnose problems in your lungs or bones? ○ ○

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8.A. At anytime during the last 6 months, have you been admitted to the hospital for any reason? This would include staying overnight or being admitted for a procedure that was done in one day. Please include all medical and psychiatric hospitalizations. This doesn't include being treated in the emergency room and later released.

○ No → **SKIP TO Q 9**

○ Yes

How many separate times did you stay overnight as a patient in a hospital in the last 6 months?

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

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

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

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

MO		J F M A M J J A S O N D
DAY		0 10 20 30
		0 1 2 3 4 5 6 7 8 9
YEAR		91 92 93 94 95 96 97 98 99 00 01 02

b. How many nights did you spend in the hospital at that time?

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

NIGHTS

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

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

IF ONLY ONE HOSPITALIZATION (SEE RESPONSE TO 8.A.), SKIP TO QUESTION 9

(2) a. For your second most recent hospitalization, on what date did you go into the hospital?

MO		J F M A M J J A S O N D
DAY		0 10 20 30
		0 1 2 3 4 5 6 7 8 9
YEAR		91 92 93 94 95 96 97 98 99 00 01 02

b. How many nights did you spend in the hospital at that time?

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

NIGHTS

8.B. (2) c. For what condition or problem were you hospitalized and the name/address of the hospital?
RECORD FULLY IN R's OWN WORDS.

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

d. Did you have any other prior hospitalizations in the last 6 months?

○ No → **SKIP TO Q 9**

○ Yes

○ **IF MORE THAN 2 HOSPITALIZATIONS, MARK HERE AND USE CONTINUATION SHEET.**

e. Have you ever been hospitalized, prescribed drugs, or consulted a mental health professional for treatment of depression?

○ No

○ Yes

○ Don't Know

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

	J F M A M J J A S O N D
	87 88 89 90 91 92 93 94 95 96 97 98 99 00 01 02

→ Before 1988

9.A. We are now going to ask you about specific conditions that may have been diagnosed in either your immediate family or yourself. By immediate family, we mean your biological mother, father, brothers and sisters.

Have any members of your immediate family ever been hospitalized, prescribed drugs, or treated for depression?

○ No

○ Yes

○ Don't Know

9.B. Have any members of your immediate family ever suffered from (EACH)?

	NO	YES	DON'T KNOW
1. High blood pressure or hypertension	○	○	○
2. Pancreatitis	○	○	○
3. Diabetes or high blood sugar	○	○	○
4. Chest pain related to heart disease	○	○	○
5. Heart attack before age 60	○	○	○
6. Stroke	○	○	○
7. High blood cholesterol or high lipids	○	○	○
8. Hip fracture or broken hip before age 60	○	○	○
9. Cancer	○	○	○
	SKIP TO Q 10		**SKIP TO Q 10**

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9. B. Continued

IF YES: Was it:	NO	YES	DON'T KNOW
a. Skin Cancer	○	○	○
b. Colon Cancer	○	○	○
c. Prostate Cancer	○	○	○
d. Other Cancer	○	○	○

Specify:

10. A. Have you had a biopsy in the last 2 years?
(By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

○ No → REVIEW RESPONSE TO Q 5, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 11

○ Yes

B. How many times have you had a biopsy in the last 2 years?

0 1 2 3 4 5 6 7 8 9 TIMES

C. For each biopsy, please tell me:

	a. Where in your body?	b. What did they say the diagnosis or result of the biopsy was?	c. Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?
1)	Specify: 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor Name of hospital/center/clinic City State DATE
2)	Specify: 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor Name of hospital/center/clinic City State DATE
3)	Specify: 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	Specify: 0 1 2 3 4 5 6 7 8 9	Name of doctor Name of hospital/center/clinic City State DATE

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	NO	YES	DON'T KNOW
11. A. Have you ever received a transfusion of blood or blood parts (platelets or plasma)?	○	○	○
	SKIP TO Q 12		SKIP TO Q 12

B. How many times have you had a transfusion?
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9 TIMES

C. When was the last time?

MO		J F M A M J J A S O N D
DAY		0 10 20 30 0 1 2 3 4 5 6 7 8 9
YEAR		91 92 93 94 95 96 97 98 99 00 01 02

	NO	YES	DON'T KNOW
12. Have you ever had a flu vaccine? IF YES: How old were you when you received your last one?	○	○	○

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

	NO	YES	DON'T KNOW
13. Have you ever received an injection of Pneumococcal vaccine/Pneumovax?	○	○	○

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14. Has a doctor or other medical provider ever told you that you had (EACH)?

	NO, NEVER		YES, BUT NOT IN LAST 6 MONTHS	YES, WITHIN LAST 6 MONTHS
A. Shingles (or Herpes Zoster)	○		○	○
IF YES: Which month and year did this episode of shingles (zoster) begin? → J F M A M J J A S O N D / 91 92 93 94 95 96 97 98 99 00 01 02				
B. Thrush (yeast in your mouth)	○		○	○
IF YES: Which month and year did this episode of thrush begin? → J F M A M J J A S O N D / 91 92 93 94 95 96 97 98 99 00 01 02				
C. Infectious Mononucleosis	○		○	○
D. Sickle Cell Anemia	○		○	○
E. Sinusitis (a sinus infection that requires antibiotics)	○		○	○
F. Bronchitis	○		○	○
G. Pancreatitis	○		○	○
H. High Blood Pressure or Hypertension	○		○	○
I. Injury to head with loss of consciousness	○		○	○
J. Chest pain or Angina	○		○	○
K. Heart attack	○		○	○
L. Congestive Heart Failure or CHF	○		○	○
M. Stroke or CVA	○		○	○
N. Seizure	○		○	○
O. Osteoporosis (bone thinning)	○		○	○
P. Kidney Disease	○		○	○
Q. Arthritis	○	SKIP TO R	○	○
IF YES: Was it: (Read and answer each.) → Rheumatoid	○		○	○
Osteoarthritis or degenerative	○		○	○
Other	○		○	○
Specify:				
Don't know what type ○				
R. Avascular Necrosis or had a hip replacement	○		○	○
S. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis.]	○	SKIP TO T	○	○
IF YES: Was it: (Read and answer each.) → Hepatitis A or Infectious Hepatitis	○		○	○
Hepatitis B or Serum Hepatitis	○		○	○
Hepatitis C	○		○	○
Other	○		○	○
Specify:				
Don't know what type ○				
T. Liver Disease	○	SKIP TO U	○	○
IF YES: Was it: → Cirrhosis	○		○	○
Fibrosis	○		○	○
Inflammation	○		○	○
Elevated liver function test enzyme	○		○	○
Other	○		○	○
Specify:				
Don't know what type ○				
U. Have you ever received an injection of Hepatitis A vaccine?	○		○	○
V. Have you ever received an injection of Hepatitis B vaccine?	○		○	○

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15. **Have you ever had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system?** NO ○ YES ○

IF YES: Was there a diagnosis for your condition? ○ ○

IF YES: What was the diagnosis?

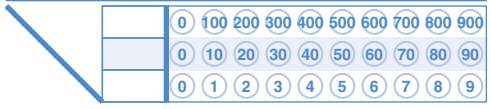
Specify:

16. **In the last 2 years, have you seen a doctor or other medical provider for any (other) conditions or problems in the following areas?**

NO YES

a) **Affecting the whole body** ○ ○
IF YES: What was the diagnosis?

Specify:



b) **Eyes** ○ ○
IF YES: What was the diagnosis?

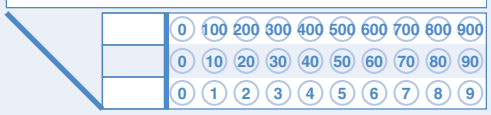
Specify:

c) **Ears, Nose, Throat, Mouth** ○ ○
IF YES: What was the diagnosis?

Specify:

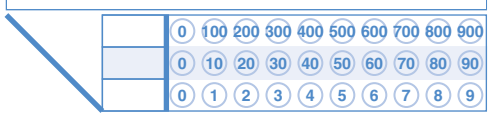
d) **Heart** ○ ○
IF YES: What was the diagnosis?

Specify:



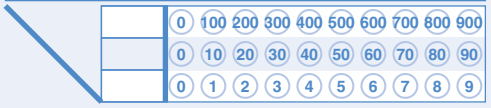
e) **Lungs** ○ ○
IF YES: What was the diagnosis?

Specify:



f) **Stomach and Intestines** ○ ○
IF YES: What was the diagnosis?

Specify:

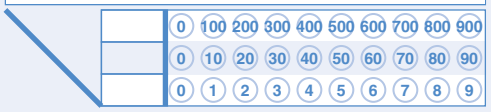


g) **Bones, Joints or Muscles** ○ ○
IF YES: What was the diagnosis?

Specify:

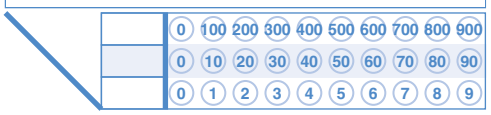
h) **Genital and Urinary** ○ ○
IF YES: What was the diagnosis?

Specify:



i) **Skin** ○ ○
IF YES: What was the diagnosis?

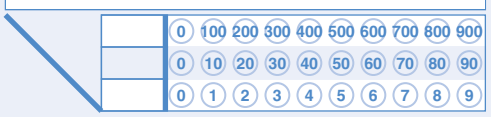
Specify:



NO YES

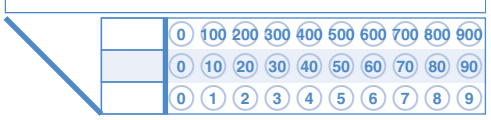
j) **Nervous system** ○ ○
IF YES: What was the diagnosis?

Specify:



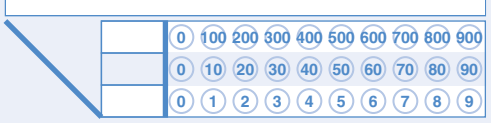
k) **Psychological** ○ ○
IF YES: What was the diagnosis?

Specify:



l) **Hormones** ○ ○
IF YES: What was the diagnosis?

Specify:



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16. Continued

	NO	YES
m) Blood and Fluids	○	○

IF YES: What was the diagnosis?

Specify:

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

n) Allergy and Immune system	○	○

IF YES: What was the diagnosis?

Specify:

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

o) Other	○	○

IF YES: What was the diagnosis?

Specify:

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Specify:

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

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17.A. Have you ever had any of the following forms of herpes, not including shingles or herpes zoster?

	NO	YES
1) Facial herpes, cold sores, or fever blisters	○	○
2) Sores in genital region	○	○
3) Sores in the anal or rectal areas	○	○
4) Sores elsewhere on your body	○	○

IF "NO" TO ALL FOUR, SKIP TO Q 18

B. Was the first attack of herpes in the past 6 months? ○ ○

C. Has there been a period during the past 6 months when your (herpes) sores seemed to come more often, get worse or last longer than usual? ○ ○

18. Have you ever had any of the following diseases or conditions?
How about (EACH)?

DISEASE OR CONDITION	a EVER HAD DISEASE NO	a EVER HAD DISEASE YES	b LAST 6 MONTHS? NO	b LAST 6 MONTHS? YES
A) Syphilis	○ GO TO NEXT ROW	○	○	○
B) Any form of gonorrhea	○	○	○	○
C) Urethral gonorrhea (clap or drip of the urinary passage)	○	○	○	○
D) Oral gonorrhea (of the mouth or throat)	○	○	○	○
E) Rectal gonorrhea (of the rectum)	○	○	○	○
F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that's not caused by gonorrhea)	○ GO TO NEXT ROW	○	○	○
G) Genital warts or anal warts (condylomata acuminata)	○ GO TO NEXT ROW	○	○	○
H) Chlamydia	○ GO TO NEXT ROW	○	○	○
I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis	○ GO TO NEXT ROW	○	○	○

IF "NO" TO (B), SKIP TO (F)

Specify:

19.A. Have you had any of the following problems or symptoms during the last 6 months?

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, AND c.	a How about (EACH)? Did you have that at any time during the last 6 months?		b Did that last for two weeks or longer?		c And do you have that now?	
	NO	YES	NO	YES	NO	YES
1) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	○	○	○	○	○	○
2) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	○	○	○	○	○	○
3) Diarrhea for at least 3 consecutive days	○	○	○	○	○	○
4) Persistent or recurring fever higher than 100° for at least 3 consecutive days	○	○	○	○	○	○
5) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	○	○	○	○	○	○
6) Persistent, frequent or unusual kinds of head-aches for at least 3 consecutive days	○	○	○	○	○	○
7) Drenching sweats at night on at least 3 occasions	○	○	○	○	○	○
8) Candida or white patches in you mouth or throat	○	○	○	○	○	○
9) Joint pain	○	○	○	○	○	○
10) Ascites (fluid buildup in the stomach or abdomen)	○	○	○	○	○	○
11) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	○	○	○	○	○	○
12) An unusual bruise or bump or skin discoloration that lasted at least two weeks	○	○			○	○
13) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	○	○			○	○
14) Anemia, low RBC, low hemoglobin	○	○			○	○
15) Unusual bleeding or bleeding that is difficult to stop	○	○			○	○
16) Persistent dizziness for at least 3 consecutive days	○	○	○	○	○	○

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19.A. Continued

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, AND c.	a How about (EACH)? Did you have that at any time during the last 6 months?		b Did that last for two weeks or longer?		c And do you have that now?	
	NO	YES	NO	YES	NO	YES
17) Nausea, vomiting	○	○	○	○	○	○
18) Abdominal pain, bloating, cramps	○	○	○	○	○	○
19) Muscle pain or weakness	○	○	○	○	○	○
20) Kidney stones	○	○			○	○
21) High blood sugar, diabetes	○	○	○	○	○	○
22) High cholesterol, high triglycerides or high lipids	○	○	○	○	○	○
23) Painful urination	○	○	○	○	○	○
24) Fat maldistribution or abnormal changes in body fat	○	○	○	○	○	○
25) Vivid nightmares or dreams	○	○	○	○	○	○
26) Insomnia or problems sleeping	○	○	○	○	○	○

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19.B. In the last 6 months have you experienced:

	If NO, go to next question. If YES, indicate severity. NO	YES		Severity (0= None, 1= Mild, 10= Severe)
1. Pain, aching, or burning in your feet or legs?	○	○	→	Right 0 1 2 3 4 5 6 7 8 9 10
				Left 0 1 2 3 4 5 6 7 8 9 10
2. Pins and needles in your feet or legs?	○	○	→	Right 0 1 2 3 4 5 6 7 8 9 10
				Left 0 1 2 3 4 5 6 7 8 9 10
3. Numbness (lack of feeling) in your feet or legs?	○	○	→	Right 0 1 2 3 4 5 6 7 8 9 10
				Left 0 1 2 3 4 5 6 7 8 9 10

20.A. Has a doctor or other medical provider tested your blood to see if you have HIV that is resistant to certain drugs?

- ○ No → **SKIP TO Q 21**
- ○ Yes

B. What type of test was done?

	NO	YES	DON'T KNOW
1) Phenotype	○	○	○
2) Genotype	○	○	○

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

- ○ No
- ○ Yes
- ○ Don't know

21. Have you ever 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.)

- ○ No
- ○ Yes → **SKIP TO Q 21.B (1)**

21.A. IF NO: Why are you not taking HIV-related medications?

READ EACH, MARK ALL THAT APPLY

- ○ Not infected with HIV → **SKIP TO Q 22**
- ○ Doctor said was not necessary
- ○ Not sick
- ○ Too expensive
- ○ Don't think they work or will help
- ○ Possible side effects
- ○ Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
- ○ Other reason

Specify:

SKIP TO Q 22

21.B. (1) Have you taken any medication or drug on this list [SHOW LIST 1 AND MEDICATION PHOTO CARDS]? Please identify those medications that you have taken as I read/show you each one. How about (EACH)?

MEDICATION	a Ever taken NO	a Ever taken YES	b Year started	c Taken in last 6 months NO	c Taken in last 6 months YES
3-TC (Epivir, Lamivudine)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Abacavir (Ziagen)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Amprenavir (Agenerase)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
AZT (Retrovir, Zidovudine)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Atazanavir (BMS-232632)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Combivir (AZT & 3-TC)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
d4T (Zerit, Stavudine)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
ddC (dideoxycytidine, HIVID, Zalcitabine)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
ddI (dideoxyinosine, Didanosine, Videx)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Delavirdine	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Efavirenz (Sustiva)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Indinavir (Crixivan)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○

21.B. (1) Continued

MEDICATION	a Ever taken: NO	a Ever taken: YES	b Year started	c Taken in last 6 months: NO	c Taken in last 6 months: YES
Lopinavir/r (Kaletra)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Nelfinavir (Viracept)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Nevirapine (Viramune)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Ritonavir (Norvir)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Saquinavir (Invirase, Fortovase)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Tenofovir (Viread)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Trizivir (abacavir+zidovudine+lamivudine)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
T-20 (Pentafuside)	○	○	90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Other anti-viral from Drug List 1	○	○			
Specify: 0 100 200 300 400 500 600 700 800 900 / 0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9			90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Specify: 0 100 200 300 400 500 600 700 800 900 / 0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9			90 91 92 93 94 95 96 97 98 99 00 01 02	○	○
Specify: 0 100 200 300 400 500 600 700 800 900 / 0 10 20 30 40 50 60 70 80 90 / 0 1 2 3 4 5 6 7 8 9			90 91 92 93 94 95 96 97 98 99 00 01 02	○	○

IF "YES" TO ANY DRUGS TAKEN IN THE LAST 6 MONTHS, SKIP TO Q 21.B. (3).

(2) IF NO USE IN LAST 6 MONTHS:

Why are you not taking HIV-related medications?

READ EACH, MARK ALL THAT APPLY

- ○ Doctor said was not necessary
- ○ Not sick
- ○ Too expensive
- ○ Don't think they work or will help
- ○ Possible side effects
- ○ Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
- ○ Other reason

Specify:

SKIP TO Q 21.C

(3) In the past 6 months, did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?

- ○ No → **SKIP TO Q 21.C**
- ○ Yes

IF YES: How many times did this occur?

0 10 20 30 40 50 60 70 80 90

0 1 2 3 4 5 6 7 8 9

Did your physician prescribe or agree to any of these?

○ No ○ Yes

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

0 10 20 30 40 50 60 70 80 90

0 1 2 3 4 5 6 7 8 9

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 21.B (1) AS TAKEN IN LAST 6 MONTHS

21.C. (1) In the past 6 months, have you taken any medication or drug on this list [SHOW LIST 2] to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- ○ No → **SKIP TO Q 21.D**
- ○ Yes

(2) Please name those drugs that you have taken. (FILL IN THE BUBBLE NEXT TO THE DRUG(S). FOR DRUGS NOT ON THE LIST, RECORD THE NAME UNDER "OTHER" AS STATED BY THE PARTICIPANT.)

- ○ Atovaquone (BW566C80, Mepron)
- ○ Azithromycin (Zithromax)
- ○ Bactrim (Septra)
- ○ Ciprofloxacin (CIPRO)
- ○ Clarithromycin (Biaxin)
- ○ Co-enzyme Q
- ○ Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
- ○ Dapsone
- ○ DHEA
- ○ Ethambutol
- ○ Erythropoietin (Epogen)
- ○ Flagyl (metronidazole)
- ○ Fluconazole (Diflucan)
- ○ Ganciclovir (DHPG)
- ○ Hydroxyurea (Hydrea)
- ○ Interleukin-2 (IL-2)
- ○ Itraconazole
- ○ Ketoconazole (Nizoral)
- ○ Megace
- ○ Mycelex (clotrimazole)
- ○ NAC (N-acetyl-cysteine)
- ○ Nandralone (Deca-Durabolin)
- ○ Nystatin (Mycostatin)
- ○ Oxandrin
- ○ Pentamidine (aerosolized)
- ○ Rifabutin (Ansamycin, Mycobutin)
- ○ Testosterone (Delatestryl, Virilon)
- ○ Vaccine trial (generic)
- ○ Other from Drug List 2 →

1. ____
2. ____
3. ____

(0 100 200 300 400 500 600 700 800 900) (0 10 20 30 40 50 60 70 80 90) (0 1 2 3 4 5 6 7 8 9)

COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q 21.C (2)

D. (1) In the past 6 months, have you taken any medication, drug or other therapy that was not listed to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- ○ No → **SKIP TO Q 22**
- ○ Yes

(2) Please name the other HIV related therapies you have taken.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____

(0 100 200 300 400 500 600 700 800 900) (0 10 20 30 40 50 60 70 80 90) (0 1 2 3 4 5 6 7 8 9)

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22. Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include either prescribed drugs or other things you took on your own during the last 6 months.

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a) IF "NO" TO a GO TO NEXT ITEM	a How about (EACH)? Have you taken/used any in the last 6 months? NO / YES	b (WHEN SPECIFIED) What was the name of the (KIND OF DRUG) you took and what did you take this drug for?
1) Steroids that you took by mouth or were injected	◯ NO ◯ YES	Name: Used for:
2) Thyroid hormone or medication	◯ ◯	Name:
3) Other hormones such as anabolic steroids	◯ ◯	Name: Used for:
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	◯ ◯	Name: Used for:
5) Medication taken by mouth for fungal infection	◯ ◯	Name:
6) Medication taken by mouth for worms or parasites	◯ ◯	Name:
7) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? ◯ No ◯ Yes	◯ ◯	Name: Used for:
8) Antidepressants or mood elevators	◯ ◯	Name:
9) Lithium	◯ ◯	Used for:
10) Acyclovir, famciclovir or valacyclovir for herpes IF YES, was this for: chronic herpes? ◯ No ◯ Yes episodic herpes? ◯ No ◯ Yes	◯ ◯	Name:
11) Viagra	◯ ◯	Used for:
12) Cholesterol, triglycerides or lipid lowering medications a. (SPECIFY in column b) → 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	◯ ◯ SKIP TO Q 22.13	Name:
b. (SPECIFY in column b) → 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	◯ ◯ SKIP TO Q 22.13	Name:
13) Medications used for diabetes a. (SPECIFY in column b) → 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	◯ ◯ SKIP TO Q 22.14	Name:
b. (SPECIFY in column b) → 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	◯ ◯ SKIP TO Q 22.14	Name:

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22. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a) IF "NO" TO a GO TO NEXT ITEM	a How about (EACH)? Have you taken/used any in the last 6 months?	b (WHEN SPECIFIED) What was the name of the (KIND OF DRUG) you took and what did you take this drug for?
14) Hepatitis medications **a. (SPECIFY in column b)** →	NO YES SKIP TO Q 22.15	Name:
b. (SPECIFY in column b) →	SKIP TO Q 22.15	Name:
15) a. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
b. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
c. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
d. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
e. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
f. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
g. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:
h. Other (SPECIFY in column b) →	SKIP TO Q 23	Name: Used for:

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23.A. Have you ever been given a vaccine against HIV in a trial?

○ No SKIP TO Q 24 ○ Yes

B. Do you know the name of the trial?

○ No ○ Yes → Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

C. Where did you go for this trial?

Name of hospital or clinic

Address

City State

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

24.A. Do you currently have [ASK EACH ITEM AND RECORD ANSWER]

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

Specify:

	0	1	2	3	4	5	6	7	8	9

24.B. Do you have insurance coverage that pays for all or some of your medications? NO ○ YES ○

IF NO TO Q 24.A (1)–(8) AND Q 24.B, THEN SKIP TO Q 28

25. A. In the past 6 months, have you changed or lost your medical coverage? NO ○ YES ○ → SKIP TO Q 27

B. If YES, was that change your choice? ○ ○

C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION]

	NO	YES
1) Lost or quit job	○	○
2) Changed job (employer or employment status)	○	○
3) Employer changed or dropped coverage	○	○
4) Pre-existing medical condition limited choices	○	○
5) To be able to choose doctors or providers	○	○
6) More or better coverage of needed or desired services	○	○
7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed	○	○
8) Financial reasons (cost of premiums, co-payments or deductibles)	○	○
9) Eligible for Medicare	○	○

D. [IF "YES" TO MORE THAN ONE RESPONSE IN Q 25.C, ASK] Which one was the PRIMARY reason? [READ ALL CHOICES AND SELECT ONLY ONE]

○ Lost or quit job
○ Changed job (employer or employment status)
○ Employer changed or dropped coverage
○ Pre-existing medical condition limited choices
○ To be able to choose doctors or providers
○ More or better coverage of needed or desired services
○ Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed
○ Financial reasons (cost of premiums, co-payments or deductibles)
○ Eligible for Medicare

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26. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)

	NO	YES
1) Employer offers only one plan	○	○
2) Only eligible for current coverage due to medical condition	○	○
3) To be able to choose doctors or providers	○	○
4) To have more or better coverage of needed or desired services	○	○
5) Eligible for Medicaid, Medi-Cal, or Medical Assistance	○	○
6) Financial reasons (cost of premiums, co-payments or deductibles)	○	○
7) Eligible for Medicare	○	○

27. All things considered, how satisfied are you with your current health insurance plan? [SHOW CARD TO PARTICIPANT OR READ ALOUD]

- ○ 1) Completely satisfied, couldn't be better
- ○ 2) Very satisfied
- ○ 3) Somewhat satisfied
- ○ 4) Neither satisfied nor dissatisfied
- ○ 5) Somewhat dissatisfied
- ○ 6) Very dissatisfied
- ○ 7) Completely dissatisfied, couldn't be worse

28. Did you currently have any type of dental insurance coverage?

- ○ No
- ○ Yes

29. Where do you usually go for medical care, even if you haven't received medical care in the past 6 months? [READ ALL CHOICES AND SELECT ONLY ONE]

- ○ HMO
- ○ Doctor's office (non-HMO) including Urgent Care
- ○ Any clinic
- ○ Emergency room
- ○ Other outpatient

Specify:

- ○ No regular source of medical care
- ○ Don't know

30. In the past 6 months, have you gone to ANY of the following sources for your outpatient medical care? (ASK FOR EACH ITEM) (This does not include dental health care, mental health care, home health care, clinical trials or other research studies, including MACS.) [SHOW CARD WITH EXAMPLES OF EACH CATEGORY.]

SERVICE	a. Have you used (EACH) in the past 6 months?	b. How many times? (99 = 99 or more)
1) HMO	NO ○ GO TO NEXT ROW YES ○	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
2) Doctor's office (non-HMO) including Urgent Care	NO ○ GO TO NEXT ROW YES ○	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
3) Any clinic	NO ○ GO TO NEXT ROW YES ○	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
4) Emergency room	NO ○ GO TO NEXT ROW YES ○	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
5) Other outpatient	NO ○ GO TO Q 31 YES ○	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

Specify:

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31. In the past 6 months, have you used ANY of the following providers or services?

SERVICE	a Have you used (EACH) in the past 6 months?	b How many times? (99 = 99 or more)
1) Dental health care provider (such as dentist or dental hygienist)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/counselor)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)	○ NO GO TO NEXT ROW ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)	○ NO GO TO Q 32 ○ YES	0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

32. Please estimate the TOTAL out-of-pocket expenses that you or other personal sources (your lover, family or friends) paid for your prescription medications in the past 6 months. [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN $1]

$ 0 10M 20M 30M 40M 50M 60M 70M 80M 90M
, 0 1M 2M 3M 4M 5M 6M 7M 8M 9M
0 100 200 300 400 500 600 700 800 900
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9

OR
○ Don't know
○ Refused

33.A. Was there a time in the past 6 months when you did not seek medical care, or dental care, or did not obtain prescription medications that you thought you needed?

○ No → SKIP TO Q 34
○ Yes

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

1) Medical care

○ No → GO TO (2)
○ Yes → Why did you not seek medical care?

[READ EACH AND MARK ALL THAT APPLY]

○ Financial reasons
○ Other non-financial reasons

Specify:

33.B. Continued

2) Dental care

○ No → GO TO (3)
○ Yes → Why did you not seek dental care?

[READ EACH AND MARK ALL THAT APPLY]

○ Financial reasons
○ Other non-financial reasons

Specify:

3) Prescription medications

○ No → GO TO Q 34
○ Yes → Why did you not obtain prescription medications?

[READ EACH AND MARK ALL THAT APPLY]

○ Financial reasons
○ Other non-financial reasons

Specify:

34. Was there a time in the past 6 months when you were refused care from a doctor or other medical provider?

○ No
○ Yes

35. Was there a time in the past 6 months when you were refused dental care?

○ No
○ Yes

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STOP HERE AND GO TO ACASI

36. At present, which of the following categories describes your annual income?

- ◯ Less than $10,000
- ◯ 10,000–19,999
- ◯ 20,000–29,999
- ◯ 30,000–39,999
- ◯ 40,000–49,999
- ◯ 50,000–59,999
- ◯ 60,000 or more
- ◯ Does not wish to answer

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

- ◯ No
- ◯ Yes

38. Has your employment status ever changed for any reason related to HIV disease?

- ◯ No → **SKIP TO Q 39**
- ◯ Yes

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

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

Specify:

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

39. A. Have you ever smoked cigarettes?

- ◯ No → **SKIP TO Q 40**
- ◯ Yes

B. How old were you when you began smoking (cigarettes)?

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

39. Continued

C. Do you smoke cigarettes now? (As of one month ago?)

- ◯ No → **SKIP TO (D)**
- ◯ Yes → **SKIP TO (E)**
- ◯ Occasionally (less than one cigarette per day) → **SKIP TO (F)**

D. How long ago did you stop?

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

◯ months ago **OR** ◯ years ago

NOW SKIP TO (F)

E. How many packs do you usually smoke per day?

- ◯ Less than 1/2 pack
- ◯ At least 1/2 pack; but less than one pack per day
- ◯ At least 1 but less than 2 packs
- ◯ 2 or more packs per day

F. Thinking about the period of time when you smoked the most, how many (packs of) cigarettes did you smoke per day?

- ◯ Never smoked regularly (never as much as 1 cigarette per day)
- ◯ Less than 1/2 pack a day
- ◯ At least 1/2 pack; but less than one pack per day
- ◯ At least 1 pack per day but less than 2
- ◯ 2 or more packs per day

40. The next questions are about alcoholic beverages—that is, wine, beer or liquor you've drunk.

A. Did you drink any alcoholic beverages in the past year?

- ◯ No → **SKIP TO Q 41**
- ◯ Yes

B. How often did you have a drink containing alcohol (a glass of beer, wine, a mixed drink, any kind of alcoholic beverage)?

- ◯ At least once a day
- ◯ Nearly every day
- ◯ 3 to 4 times a week
- ◯ Once or twice a week
- ◯ 2 or 3 times a month
- ◯ About once a month
- ◯ 6–11 times a year
- ◯ 1–5 times a year

C. On days when you drank any alcoholic beverages, how many drinks did you USUALLY have altogether? (By a drink we mean a can or glass of beer, a 4-ounce glass of wine, a 1 1/2-ounce shot of liquor, or a mixed drink with that amount of liquor.)

- ◯ 1 or 2 drinks
- ◯ 3 or 4 drinks
- ◯ 5 or 6 drinks
- ◯ 7 or more drinks

3/8" spine perf

240345–7/8

I would like to ask you some questions about your sexual activity. I realize that this is a very personal subject. Your answers will be completely confidential.

READ DEFINITION OF SEXUAL ACTIVITY:

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

41. Have you had any sexual activity with another person in the last 2 years?

- ○ No → **SKIP TO Q 50**
- ○ Yes

42. Have you had any sexual activity with a woman in the last 2 years?

- ○ No → **SKIP TO Q 46**
- ○ Yes

43. Have you had any sexual activity with a woman in the last 6 months?

- ○ No → **SKIP TO Q 46**
- ○ Yes

44. Now lets talk about how many different women you have had sexual activity with in the last 6 months.

A. How many different women (if any) have you had sexual intercourse with in the last 6 months? Here we define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus/butt, with or without ejaculation.

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

B. With how many other women have you had sexual activity that did not include intercourse in the last 6 months?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

The next questions are about different kinds of sexual activity men have with women.
IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 45.10

45. IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a. Did you do this/engage in this activity with a woman in the last 6 months?	b. How many women did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 2) With how many of those women did you use a condom every time for oral sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time you had oral sex even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

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45. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman in the last 6 months?	b How many women did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
IF MULTIPLE PARTNERS: 3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 5) With how many of those women did you use a condom every time for vaginal sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 6) With how many women did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 9) With how many women did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

45. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman in the last 6 months?	b How many women did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
10) You used your tongue to touch or lick her anus/butt ("rimming").	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
11) You used your tongue to touch or lick her genitals (vagina, clitoris).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

46. Have you had any sort of sexual activity with a man in the last 2 years?

○ No → SKIP TO Q 50

○ Yes

47. Have you had any sort of sexual activity with a man in the last 6 months?

○ No → SKIP TO Q 50

○ Yes

48. Now lets talk about how many different men you have had sexual activity with in the last 6 months.

A. How many different men (if any) have you had sexual intercourse with in the last 6 months? Here we define sexual intercourse as follows: you put your penis in your partner's mouth or rectum—or your partner put his penis in your mouth or rectum, with or without ejaculation.

0 100 200 300 400 500 600 700 800 900
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9

B. With how many other men have you had sexual activity that did not include intercourse in the last 6 months?

0 100 200 300 400 500 600 700 800 900
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9

3/8" spine perf

The next questions are about different kinds of sexual activity some men engage in with other men.
IF NO INTERCOURSE WITH MEN, SKIP TO Q 49.13

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

KIND OF ACTIVITY	a. Did you do this/engage in this activity with a man in the last 6 months?	b. How many men did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (5).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom every time, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 3) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 5) Thinking of the times you put your penis in their anus/butt, with how many men did you use a condom every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 6) With how many men did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

49. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man in the last 6 months?	b How many men did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 8) Thinking of the times when a man put his penis in your mouth, with how many men was a condom used every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times when he put his penis in your mouth, was a condom used every time, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 9) With how many men did ejaculate/cum go into your mouth when they did not use a condom (or when a condom failed)? IF ONE PARTNER: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 11) Thinking of the times when a man put his penis in your anus/butt, with how many men was a condom used every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times he put his penis in your anus/butt, was a condom used every time, even if it broke, tore, or slipped?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
IF MULTIPLE PARTNERS: 12) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)? IF ONE PARTNER: Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
13) You used your tongue to touch or lick his anus/butt ("rimming").	NO ○ YES ○	0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

3/8" spine perf

The next few questions are asked to summarize your past sexual practices with both female and male partners.

50. When was the last time you had sexual intercourse with a woman?

- ○ Never → SKIP TO Q 53
- ○ Within the last month
- ○ Within the last year (but not the last month)
- ○ 1–5 years ago
- ○ 6–10 years ago → SKIP TO Q 52
- ○ More than 10 years ago → SKIP TO Q 52

51. With how many different women have you had sexual intercourse in the past 2 years?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

52. With how many different women have you had sexual intercourse in your whole life?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

53. When was the last time you had sexual intercourse with a man?

- ○ Never → SKIP TO Q 56
- ○ Within the last month
- ○ Within the last year (but not the last month)
- ○ 1–5 years ago
- ○ 6–10 years ago → SKIP TO Q 55
- ○ More than 10 years ago → SKIP TO Q 55

54. With how many different men have you had sexual intercourse in the past 2 years?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

55. With how many different men have you had sexual intercourse in your whole life?

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

56. In summary, which of the following statements best describes your sexual activity during the last 2 years?

- ○ Had sexual activity only with women
- ○ Had sexual activity mostly with women, but some men
- ○ Had sexual activity about equally with women and men
- ○ Had sexual activity mostly with men, but some women
- ○ Had sexual activity only with men

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240345–4/8

57. Now let's talk about other drugs you may have used. As I read each one, please tell me whether you used it, even once during the last two years?

	a. How about (EACH) Have you (taken/used) any in the last 2 years?	b. Have you taken/used (DRUG) in the last 6 months?	c. How often did you (use/take) (DRUG) during the last 6 months?			
			DAILY	WEEKLY	MONTHLY	LESS OFTEN
Pot, Marijuana or Hash	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Crack or cocaine that you smoke	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Other forms of cocaine	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Speed, Meth or Ice	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Heroin	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Speedball (heroin and cocaine together)	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Ecstasy, XTC, X or MDMA	NO ○ GO TO NEXT ROW ○ YES	NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Other kinds of street/club drugs	NO ○ GO TO Q 58 ○ YES					
Specify: ____ (0 1 2 3 4 5 6 7 8 9)		NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Specify: ____ (0 1 2 3 4 5 6 7 8 9)		NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Specify: ____ (0 1 2 3 4 5 6 7 8 9)		NO ○ GO TO NEXT ROW ○ YES	○	○	○	○
Specify: ____ (0 1 2 3 4 5 6 7 8 9)		NO ○ GO TO Q 58 ○ YES	○	○	○	○

3/8" spine perf

58. A. Have you ever injected recreational drugs (skin popped, shot up with a needle)?

- ○ No → SKIP TO Q 64
- ○ Yes

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

- ○ No
- ○ Yes

C. Do you currently inject drugs?

- ○ No
- ○ Yes

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

Speedball (cocaine and heroin together)

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

Cocaine by itself

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

Heroin by itself

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

Speed by itself

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

59. In the last 6 months, have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?

- ○ No → SKIP TO Q 61
- ○ Yes

60. A. In the last 6 months, how many times have you used needles or works that were first used by someone else and then passed to you?

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

B. With how many different people?

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

61. A. In the last 6 months, have you shared water to rinse your needles with anyone?

- ○ No → SKIP TO Q 62
- ○ Yes

B. How many times?

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

C. With how many different people?

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

62. In the last 6 months, how often did you clean your works with bleach?

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

63. A. Have you participated in a needle exchange program?

- ○ No → SKIP TO Q 64
- ○ Yes

B. Of the times you obtained needles, how often did you get them from a needle exchange?

- ○ Less than half the time
- ○ Half the time
- ○ Most of the time
- ○ Always

C. Do you have another source of clean needles?

- ○ No
- ○ Yes

64. Have you been in a drug treatment program, including inpatient and/or outpatient detox, methadone maintenance programs, halfway houses, narcotics anonymous, prison or jail-based programs and/or any other program?

- ○ No
- ○ Yes

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240345–3/8

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

- ○ No, nothing more → **THANK PARTICIPANT AND SKIP TO Q 66**
- ○ Yes

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

66. Date interview completed

67. Interviewer's signature

TIME ENDED

HR		MIN		
0	0	0	0	
10	1	10	1	AM
	2	20	2	○
	3	30	3	
	4	40	4	PM
	5	50	5	○
	6		6	
	7		7	
	8		8	
	9		9	

INTERVIEWER'S NUMBER

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

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