

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			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

VISIT NO.		
5	2	5
0	0	0
1	1	1
2	●	2
3	3	3
4	4	4
●	5	●
6	6	6
7	7	7
8	8	8
9	9	9

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

DATE			
MONTH	DAY	YEAR	
○ Jan			
○ Feb			
○ Mar	0	0	○ 10
○ Apr	1	1	○ 11
○ May	2	2	○ 12
○ June	3	3	○ 13
○ July		4	○ 14
○ Aug		5	○ 15
○ Sept		6	○ 16
○ Oct		7	○ 17
○ Nov		8	○ 18
○ Dec		9	○ 19

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.

3/8" spine part

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

1. Since we last saw you, have you been diagnosed with an AIDS-defining illness or AIDS?

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 YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
B. Pneumocystis carinii pneumonia (PCP)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
C. Other pneumonia or lung infections other than bronchitis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
D. Toxoplasmosis or Toxo Infection	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
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.) <input type="radio"/> Eyes <input type="radio"/> Lung <input type="radio"/> Colon <input type="radio"/> Other (not blood) Specify: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
F. MAI, MAC or Mycobacterial infection	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
G. Lymphoma, specify <input type="radio"/> Primary brain lymphoma <input type="radio"/> Non-Hodgkin's <input type="radio"/> Other Specify: <input type="text"/>	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
H. Meningitis related to HIV or Cryptococcal Meningitis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
I. Cryptococcal Infection without Meningitis	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
J. Candida or thrush, a yeast infection of the esophagus (the tube between your mouth and stomach)	NO YES <input type="radio"/> <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		

GET MEDICAL RELEASE

1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it first diagnosed?																										
K. Cryptosporidiosis	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
L. Wasting syndrome or severe weight loss	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
M. Herpes Simplex Infection of the lungs or esophagus (the tube between your mouth and stomach)	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
N. Histoplasmosis Infection or Histo	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		
O. Cocci, Coccidioidomycosis infection or valley fever	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
P. Dementia or Encephalopathy or a memory problem or confusion caused by HIV	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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Q. Infection in the blood with a bacterium called Salmonella	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
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	10	11	12	13	14	15	16	17	18	19																		
R. PML, Progressive Multifocal Leukoencephalopathy, a disease of the brain	NO <input type="radio"/> YES <input type="radio"/> GO TO Q 2	<table border="1"> <tr> <td></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td></td> <td>10</td><td>11</td><td>12</td><td>13</td><td>14</td><td>15</td><td>16</td><td>17</td><td>18</td><td>19</td><td></td><td></td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		10	11	12	13	14	15	16	17	18	19		
	J	F	M	A	M	J	J	A	S	O	N	D																
	10	11	12	13	14	15	16	17	18	19																		

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.

A. Have you ever had a skin test for TB, sometimes called a PPD? NO YES

SKIP TO Q 3

B. IF YES: When was your last test?

J	F	M	A	M	J	J	A	S	O	N	D
01	02	03	04	05	06	07	08	09	10		
11	12	13	14	15	16	17	18	19			

C. Was it positive?

3/8" spine part

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		01	02	03	04	05	06	07	08	09	10			
		11	12	13	14	15	16	17	18	19				

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		01	02	03	04	05	06	07	08	09	10			
		11	12	13	14	15	16	17	18	19				

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 8.C**
 Yes ↓

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

8.C. 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
		01	02	03	04	05	06	07	08	09	10		
		11	12	13	14	15	16	17	18	19			

Before 2002

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

- Not applicable for those participants who do not have living blood-related family members or do not know them because they are adopted. **SKIP TO Q 10**

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Pancreatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Diabetes or high blood sugar	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Chest pain related to heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Heart attack before age 60	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Congestive Heart Failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Mini-strokes or transient ischemic attacks (TIA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. High blood cholesterol or high lipids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Hip fracture or broken hip before age 60	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SKIP TO Q 10

SKIP TO Q 10

3/8" spine part

9. B. Continued

IF YES: Was it:

NO YES DON'T KNOW

- a. Skin Cancer NO YES DON'T KNOW
- b. Colon Cancer NO YES DON'T KNOW
- c. Prostate Cancer NO YES DON'T KNOW
- d. Other Cancer NO YES DON'T KNOW

Specify: _____

Now we would like to talk about your specific conditions.

10. A. Have you had any biopsies of the skin or other tissues and organs in the last two years, other than from the anus or rectum? By biopsy, we mean removal of any tissue or gland to study under the microscope. We will ask you about anal and rectal biopsies later on.

- No
- Yes

REVIEW RESPONSE TO Q 5, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 11

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

<input type="text"/>	0 1 2 3 4 5 6 7 8 9	TIMES
----------------------	---------------------	-------

C. For each biopsy, please tell me:

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

GET MEDICAL RELEASE

11. A. Have you ever received a transfusion of blood or blood parts (platelets or plasma)?

- NO
- YES
- DON'T KNOW

SKIP TO Q 12

SKIP TO Q 12

B. How many times have you had a transfusion?

<input type="text"/>	0 10 20 30 40 50 60 70 80 90	TIMES
<input type="text"/>	0 1 2 3 4 5 6 7 8 9	

C. When was the last time?

MO	<input type="text"/>	J F M A M J J A S O N D
DAY	<input type="text"/>	0 10 20 30 0 1 2 3 4 5 6 7 8 9
YEAR	<input type="text"/>	01 02 03 04 05 06 07 08 09 10 11 12 13 14 15 16 17 18 19

12. Have you ever had a flu vaccine? IF YES: How old were you when you received your last one?

- NO
- YES
- DON'T KNOW

<input type="text"/>	0 10 20 30 40 50 60 70 80 90
<input type="text"/>	0 1 2 3 4 5 6 7 8 9

13. Have you ever received an injection of Pneumococcal vaccine/Pneumovax?

- NO
- YES
- DON'T KNOW

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? →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B. Thrush (yeast in your mouth) IF YES: Which month and year did this episode of thrush begin? →	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
C. Infectious Mononucleosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D. Sickle Cell Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E. Sinusitis (a sinus infection that requires antibiotics)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F. Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G. Pancreatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H. High Blood Pressure or Hypertension	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I. Injury to head with loss of consciousness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
J. Angina or chest pain caused by your heart	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
K. Heart attack or myocardial infarction (MI)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
L. Congestive Heart Failure or CHF	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
M. Stroke or cerebrovascular accident (CVA)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
N. Seizure or convulsions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
O. Osteoporosis (bone thinning)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
P. Kidney Disease/Renal failure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Q. Arthritis IF YES: Was it: → Rheumatoid (Read and answer each.) Osteoarthritis or degenerative Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify: <input type="text"/>			
Don't know what type <input type="radio"/>			
R. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
S. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis.] IF YES: Was it: → Hepatitis A or Infectious Hepatitis (Read and answer each.) Hepatitis B or Serum Hepatitis Hepatitis C Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify: <input type="text"/>			
Don't know what type <input type="radio"/>			
T. Liver Disease IF YES: Was it: → Cirrhosis Fibrosis Inflammation Elevated liver function test enzyme Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify: <input type="text"/>			
Don't know what type <input type="radio"/>			
U. Have you <u>ever</u> received an injection of Hepatitis A vaccine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
V. Have you <u>ever</u> received an injection of Hepatitis B vaccine?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3/8" spine part

GET MEDICAL RELEASE

GET MEDICAL RELEASE

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:

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

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:

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

b) Eyes
IF YES: What was the diagnosis?

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

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

d) Heart
IF YES: What was the diagnosis?

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

e) Lungs
IF YES: What was the diagnosis?

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

f) Stomach and Intestines NO YES
IF YES: What was the diagnosis?

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

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

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

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

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

i) Skin
IF YES: What was the diagnosis?

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

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

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

k) Treatment of depression, anxiety or other mental health problems
IF YES: What was the diagnosis?

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

l) Hormones
IF YES: What was the diagnosis?

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

16. Continued

NO YES

m) Blood and Fluids

IF YES: What was the diagnosis?

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

n) Allergy and Immune system

IF YES: What was the diagnosis?

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

o) Other

IF YES: What was the diagnosis?

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

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

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

Name of hospital/clinic or doctor

Address

City

State

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

Name of hospital/clinic or doctor

Address

City

State

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		b LAST 6 MONTHS?	
	NO	YES	NO	YES
A) Syphilis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
B) Any form of gonorrhea	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
IF "NO" TO (B), SKIP TO (F)				
C) Urethral gonorrhea (clap or drip of the urinary passage)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
D) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
E) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that's not caused by gonorrhea)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
G) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
H) Chlamydia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify:

3/8" spine part

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		b		c	
	How about (EACH)? Did you have that at any time during the last 6 months?		Did that last for two weeks or longer?		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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3) Diarrhea for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7) Drenching sweats at night on at least 3 occasions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8) Candida or white patches in your mouth or throat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9) Joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10) Ascites (fluid buildup in the stomach or abdomen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12) An unusual bruise or bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
13) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
14) Anemia, low RBC, low hemoglobin	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
15) Unusual bleeding or bleeding that is difficult to stop	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>
16) Persistent dizziness for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18) Abdominal pain, bloating, cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19) Muscle pain or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20) Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21) Painful urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
22) Fat maldistribution or abnormal changes in body fat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
23) Vivid nightmares or dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
24) Insomnia or problems sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
25) Anal bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
26) Persistent dry mouth	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

	If NO, go to next question. If YES, indicate severity.			Severity (0= None, 1= Mild, 10= Severe)												
	NO	YES		Right	Left	0	1	2	3	4	5	6	7	8	9	10
1. Pain, aching, or burning in your feet or legs?	<input type="radio"/>	<input type="radio"/>	→	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?	<input type="radio"/>	<input type="radio"/>	→	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?	<input type="radio"/>	<input type="radio"/>	→	Right		0	1	2	3	4	5	6	7	8	9	10
				Left		0	1	2	3	4	5	6	7	8	9	10

3/8" spine part

20.A. Has a doctor or other medical provider tested your blood to see if you have HIV that is resistant to certain drugs? I am referring to the types of HIV drug resistant tests that are called genotyping and phenotyping.

No → **SKIP TO Q 21**
 Yes

B. 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		b Year started		c Taken in last 6 months	
	NO	YES			NO	YES
3-TC (Epidur, Lamivudine) (204)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Abacavir (Ziagen) (218)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Atripla (efavirenz + emtricitabine + tenofovir) (262)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
fosamprenavir (Lexiva) (249)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Atazanavir (BMS-232632, Reyataz) (243)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Combivir (AZT & 3-TC) (227)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
d4T (Zerit, Stavudine) (159)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
darunavir (Prezista) (256)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
ddI (dideoxyinosine, Didanosine, Videx) (147)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Epzicom (abacavir + lamivudine) (254)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Efavirenz (Sustiva) (220)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>
Etravirine (Intelence, TMC-125) (255)	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> 01 <input type="checkbox"/> 02 <input type="checkbox"/> 03 <input type="checkbox"/> 04 <input type="checkbox"/> 05 <input type="checkbox"/> 06 <input type="checkbox"/> 07 <input type="checkbox"/> 08 <input type="checkbox"/> 09 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19		<input type="radio"/>	<input type="radio"/>

21.B. (1) Continued

MEDICATION	a Ever taken		b Year started																	c Taken in last 6 months	
	NO	YES																		NO	YES
Lopinavir/ritonavir (Kaletra, LPV) (217)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Raltegravir (Isentress, Merck Integrase Inhibitor, MK 0158) (264)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Nevirapine (Viramune) (191)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Ritonavir (Norvir) (211)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Saquinavir (Invirase, Fortovase) (210)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Tenofovir (Viread) (234)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Trizivir (abacavir + zidovudine + lamivudine) (240)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Truvada (tenofovir + emtricitabine) (253)	<input type="radio"/>	<input type="radio"/>																		<input type="radio"/>	<input type="radio"/>
Other anti-viral from Drug List 1	<input type="radio"/>	<input type="radio"/>																			
Specify: <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9																				<input type="radio"/>	<input type="radio"/>
Specify: <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9																				<input type="radio"/>	<input type="radio"/>
Specify: <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9																				<input type="radio"/>	<input type="radio"/>

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?

<input type="text"/>	0	10	20	30	40	50	60	70	80	90
<input type="text"/>	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?

<input type="text"/>	0	10	20	30	40	50	60	70	80	90
<input type="text"/>	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.)

- | | |
|---|--|
| <input type="radio"/> atovaquone (Mepron, BW566C80) (190) | <input type="radio"/> ganciclovir (Cytovene, DHPG, valcyte, valganciclovir) (125) |
| <input type="radio"/> azithromycin (Zithromax) (152) | <input type="radio"/> interleukin 2 (IL-2) (096) |
| <input type="radio"/> Bactrim (Septra, TMP/SMX) (112) | <input type="radio"/> Marinol (dronabinol) (547) |
| <input type="radio"/> ciprofloxacin (Cipro) (153) | <input type="radio"/> Megace (megestrol acetate) (123) |
| <input type="radio"/> clarithromycin (Biaxin) (184) | <input type="radio"/> NAC (N-acetyl cysteine) (188) |
| <input type="radio"/> co-enzyme Q (196) | <input type="radio"/> Nandrolone (deca-durabolin) (232) |
| <input type="radio"/> colony stimulating factor (G-CSF, Neupogen) (157) | <input type="radio"/> Oxandrin (oxandrolone) (228) |
| <input type="radio"/> dapsone (113) | <input type="radio"/> rifabutin (Mycobutin, Ansamycin) (093) |
| <input type="radio"/> DHEA (dihydroepiandrosteronedione) (161) | <input type="radio"/> Serostim (human growth hormone) (245) |
| <input type="radio"/> erythropoietin (Epogen, Procrit, Aranesp) (117) | <input type="radio"/> testosterone (AndroGel, Androderm, Delatestryl, Striant, Testoderm, Virilon) (236) |
| <input type="radio"/> ethambutol (Myambutol) (137) | |
| <input type="radio"/> fluconazole (Diflucan) (116) | |
| <input type="radio"/> foscarnet (foscavir) (091) | |

Other from Drug List 2 (Report Acyclovir in Q 22.)

1.

	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

2.

	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.

	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

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.

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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)	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?
IF "NO" TO a GO TO NEXT ITEM	NO YES	
1) Steroids that you took by mouth or were injected	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
2) Thyroid hormone or medication	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
3) Other hormones such as anabolic steroids	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
5) Medication taken by mouth for fungal infection	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
6) Medication taken by mouth for worms or parasites	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
7) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
8) Antidepressants or mood elevators	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
9) Lithium	<input type="radio"/> NO <input type="radio"/> YES	Used for: _____
10) Acyclovir, famciclovir or valacyclovir for herpes (zovir, famvir, valtrex) IF YES, was this for: chronic herpes? <input type="radio"/> No <input type="radio"/> Yes episodic herpes? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____
11) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	<input type="radio"/> NO <input type="radio"/> YES	Used for: _____
12) Cholesterol, triglycerides or lipid lowering medications a. (SPECIFY in column b)	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 22.13	Name: _____ Used for: _____
b. (SPECIFY in column b)	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 22.13	Name: _____ Used for: _____
13) Medications used for diabetes a. (SPECIFY in column b)	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 22.14	Name: _____ Used for: _____
b. (SPECIFY in column b)	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 22.14	Name: _____ Used for: _____

3/8" spine part

<p>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a)</p> <p>IF "NO" TO a GO TO NEXT ITEM</p>	<p>a How about (EACH)? Have you taken/used any in the last 6 months?</p>	<p>b (WHEN SPECIFIED) What was the name of the (KIND OF DRUG) you took and what did you take this drug for?</p>																																								
<p>14) Hepatitis medications</p> <p>a. (SPECIFY in column b)</p> <table border="1" data-bbox="196 239 578 333"> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	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	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 22.15</p>	<p>Name:</p>										
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<p>15) Hypertension medications</p> <p>a. (SPECIFY in column b)</p> <table border="1" data-bbox="196 558 578 684"> <tr><td>0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td></tr> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	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	<p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 23</p>	<p>Name:</p> <p>Used for:</p>
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<p>16) a. Other (SPECIFY in column b)</p> <table border="1" data-bbox="196 940 578 1066"> <tr><td>0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td></tr> <tr><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	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	<p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 23</p>	<p>Name:</p> <p>Used for:</p>
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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 →

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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	<input type="radio"/>	<input type="radio"/>
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)	<input type="radio"/>	<input type="radio"/>
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)	<input type="radio"/>	<input type="radio"/>
4) Medicaid, Medi-Cal, or Medical Assistance	<input type="radio"/>	<input type="radio"/>
5) Medicare (for people over 65 or permanently disabled)	<input type="radio"/>	<input type="radio"/>
6) Health care benefits for The Armed Forces or Veteran's Administration	<input type="radio"/>	<input type="radio"/>
7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans	<input type="radio"/>	<input type="radio"/>
8) Other, such as ADAP or Ryan White	<input type="radio"/>	<input type="radio"/>

Specify:

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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	<input type="radio"/>	<input type="radio"/>
2) Changed job (employer or employment status)	<input type="radio"/>	<input type="radio"/>
3) Employer changed or dropped coverage	<input type="radio"/>	<input type="radio"/>
4) Pre-existing medical condition limited choices	<input type="radio"/>	<input type="radio"/>
5) To be able to choose doctors or providers	<input type="radio"/>	<input type="radio"/>
6) More or better coverage of needed or desired services	<input type="radio"/>	<input type="radio"/>
7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed	<input type="radio"/>	<input type="radio"/>
8) Financial reasons (cost of premiums, co-payments or deductibles)	<input type="radio"/>	<input type="radio"/>
9) Eligible for Medicare	<input type="radio"/>	<input type="radio"/>

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

3/8" spine part

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	<input type="radio"/>	<input type="radio"/>
2) Only eligible for current coverage due to medical condition	<input type="radio"/>	<input type="radio"/>
3) To be able to choose doctors or providers	<input type="radio"/>	<input type="radio"/>
4) To have more or better coverage of needed or desired services	<input type="radio"/>	<input type="radio"/>
5) Eligible for Medicaid, Medi-Cal, or Medical Assistance	<input type="radio"/>	<input type="radio"/>
6) Financial reasons (cost of premiums, co-payments or deductibles)	<input type="radio"/>	<input type="radio"/>
7) Eligible for Medicare	<input type="radio"/>	<input type="radio"/>

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. Do 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		b	
	Have you used (EACH) in the past 6 months?		How many times? (99 = 99 or more)	
1) HMO	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
2) Doctor's office (non-HMO) including Urgent Care	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
3) Any clinic	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
4) Emergency room	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>
5) Other outpatient	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/>

Specify:

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)	<input type="radio"/> NO GO TO NEXT ROW <input type="radio"/> YES	<table border="1"> <tr> <td></td> <td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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32. DROPPED

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.A**
- 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.A
 - Yes → Why did you not obtain prescription medications?
- [READ EACH AND MARK ALL THAT APPLY]**
- Financial reasons
 - Other non-financial reasons

Specify:

34. DROPPED

3/8" spine part

35.E.1 Were you diagnosed with any broken or fractured bone(s) on or after the age of 30?

No Yes Not applicable (younger than 30)

IF "NO," GO TO 36

If yes... Tell me about each separate incident in which you had broken or fractured one or more bones, starting with the most recent:

Incident 1

35.E.1a What was fractured?

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

35.E.1b How old were you when this happened?

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

35.E.1c Did that fracture occur... (Select one option)

- 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

Incident 2

35.E.2a What was fractured?

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

35.E.2b How old were you when this happened?

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

35.E.2c Did that fracture occur... (Select one option)

- 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

3/8" spine part

Incident 3

35.E.3a What was fractured?

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

35.E.3b How old were you when this happened?

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

35.E.3c Did that fracture occur... (Select one option)

- 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

Incident 4

35.E.4a What was fractured?

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

35.E.4b How old were you when this happened?

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

35.E.4c Did that fracture occur... (Select one option)

- 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

Incident 5

35.E.5a What was fractured?

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

Specify: *See Appendix 9 in guidelines for list of fracture site codes.*

	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

35.E.5b How old were you when this happened?

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

35.E.5c Did that fracture occur... (Select one option)

- 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
- More than 5 diagnosed fracture incidents

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	<input type="radio"/>	<input type="radio"/>
2) HIV status became known to employer	<input type="radio"/>	<input type="radio"/>
3) HIV status became known to coworkers	<input type="radio"/>	<input type="radio"/>
4) Early retirement	<input type="radio"/>	<input type="radio"/>
5) Changed job as a personal decision	<input type="radio"/>	<input type="radio"/>
6) To receive better health insurance benefits	<input type="radio"/>	<input type="radio"/>
7) To receive better disability benefits	<input type="radio"/>	<input type="radio"/>
8) Other	<input type="radio"/>	<input type="radio"/>

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)?

	0	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 part

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?

Radio buttons for No and Yes. No is selected with an arrow pointing to a box labeled 'SKIP TO Q 50'.

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

Radio buttons for No and Yes. No is selected with an arrow pointing to a box labeled 'SKIP TO Q 46'.

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

Radio buttons for No and Yes. No is selected with an arrow pointing to a box labeled 'SKIP TO Q 46'.

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.

Three rows of a horizontal scale from 0 to 900 for counting women.

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

Three rows of a horizontal scale from 0 to 900 for counting women.

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.

Table with 3 columns: KIND OF ACTIVITY, Column a (Did you do this/engage in this activity with a woman in the last 6 months?), and Column b (How many women did you do that with [in the last 6 months]?).

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?)																																	
<p>IF MULTIPLE PARTNERS:</p> <p>3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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	0	1	2	3	4	5	6	7	8	9																									
<p>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>IF MULTIPLE PARTNERS:</p> <p>5) With how many of those women did you use a condom <u>every</u> time for vaginal sex, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Did you use a condom <u>every</u> time for vaginal sex, even if it broke, tore, or slipped?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>IF MULTIPLE PARTNERS:</p> <p>6) With how many women did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>IF MULTIPLE PARTNERS:</p> <p>8) With how many of those women did you use a condom <u>every</u> time for anal sex, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Did you use a condom <u>every</u> time for anal sex, even if it broke, tore, or slipped?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>IF MULTIPLE PARTNERS:</p> <p>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)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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3/8" spine part

45. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a	b																																	
	Did you do this/engage in this activity with a woman in the last 6 months?	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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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	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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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	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

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?)																																	
<p>1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (5).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>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)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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	0	1	2	3	4	5	6	7	8	9																									

<p>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>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 <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times you put your penis in his anus/butt, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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<p>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)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		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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3/8" spine part

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? NO YES <input type="radio"/> <input type="radio"/>	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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<p>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 <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times when he put his penis in your mouth, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<p>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)?</p> <p>IF ONE PARTNER: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</p>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<input type="text"/>	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 <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<p>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 <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times he put his penis in your anus/butt, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<p>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)?</p> <p>IF ONE PARTNER: Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</p>	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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13) You used your tongue to touch or lick his anus/butt ("rimming").	NO YES <input type="radio"/> <input type="radio"/>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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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

3/8" spine part

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		b		c			
	How about (EACH) Have you (taken/used) any in the last 2 years?		Have you taken/used (DRUG) in the last 6 months?		How often did you (use/take) (DRUG) during the last 6 months?			
	NO	YES	NO	YES	DAILY	WEEKLY	MONTHLY	LESS OFTEN
Pot, Marijuana or Hash	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack or cocaine that you smoke	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other forms of cocaine	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speed, Meth or Ice	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speedball (heroin and cocaine together)	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy, XTC, X or MDMA	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction (Show list of performance enhancing drugs to prompt and assist with recall.)	NO <input type="radio"/>	YES <input type="radio"/>	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other kinds of street/club drugs	NO <input type="radio"/>	YES <input type="radio"/>						
Specify:	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>		NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify:	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>		NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify:	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>		NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Specify:	<input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>		NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

