

a. QUESTION NUMBER	b. DATE OF FIRST DIAGNOSIS SINCE (MONTH) STUDY VISIT	c. NAME OF PROVIDER AND ADDRESS OF THE INSTITUTION
<input type="checkbox"/> B6 - Cancer _____ (SPECIFY) Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____ _____
<input type="checkbox"/> B7 - TB Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B8 - Candida Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B9 - MAC/MAI Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B10 - Wasting Syndrome Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B11 - CMV Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B12 - Shingles Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B13 - AIDS Inpatient: _____ Outpatient: _____	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____

B14. # of Hospitalizations: _____

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<input type="checkbox"/> B14i - Hospitalization (1)	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B14ii - Hospitalization (2)	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B14iii - Hospitalization (3)	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B14iv - Hospitalization (4)	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B14v - Hospitalization (5)	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____

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<input type="checkbox"/> B15a.iv - PID	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____
<input type="checkbox"/> B15a.ix - Yeast vaginitis or candida	___ ___ / ___ ___ / ___ ___ M D Y	_____ _____ _____