



WIHS ID#

	<u>YES</u>	<u>NO</u>
B5. an unintentional weight loss, of 10 pounds or more, or have you changed to a smaller clothing size, that lasted more than one month.....	<div style="border: 1px solid black; background-color: #cccccc; padding: 5px; width: 60px; margin: 0 auto;">1</div>	2
B6. confusion, getting lost in a familiar place or inability to perform routine mental tasks.....	<div style="border: 1px solid black; background-color: #cccccc; padding: 5px; width: 60px; margin: 0 auto;">1</div>	2
B7. drenching night sweats that soak night clothes or bedding.....	<div style="border: 1px solid black; background-color: #cccccc; padding: 5px; width: 60px; margin: 0 auto;">1</div>	2
B8. nausea and/or vomiting .....	1	2
B9. dry mouth .....	1	2
B10. diarrhea.....	1	2
B11. constipation .....	1	2

**REFER FOR DIFFERENTIAL DIAGNOSIS TO PARTICIPANT’S MEDICAL PROVIDER**

**INTRODUCTION:** The next series of questions asks about changes in the shape of your body that you may have noticed since your (MONTH) study visit. When thinking about these changes, please do not include any changes that have occurred due to being pregnant.

- B12. Since your (MONTH) study visit, have you noticed any changes in the shape of your body or in the amount of your body fat (either loss or gain)?
- YES..... 1
- NO..... 2 **(B13)**

To help me understand these changes, please tell me if you have noticed any of the following body changes since your (MONTH) study visit:

**PROMPT: USE THE BODY DIAGRAM CARD TO POINT OUT THE LOCATION OF THE SUPRACLAVICULAR AND DORSOCERVICAL FAT PADS, AND AS NEEDED.**

WIHS ID#

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Have you noticed...			Was this change in size an increase or a decrease?	
	YES	NO	INCREASE	DECREASE
a) A change in the size of one or both of your breasts (unrelated to pregnancy)?	1	2 <b>(b)</b>	1	2
b) A change in the size of your belly or abdominal fat?	1	2 <b>(c)</b>	1	2
c) A change in the size of your waist?	1	2 <b>(d)</b>	1	2
d) Any changes in the shape of your face?	1	2 <b>(e)</b>	1	2
e) A change in the amount of fat in your cheeks, just next to your nose and mouth?	1	2 <b>(f)</b>	1	2
f) A change in the amount of fat in your upper back?	1	2 <b>(g)</b>	1	2
g) A change in the size of your neck?	1	2 <b>(h)</b>	1	2
h) A change in the amount of fat in your arms?	1	2 <b>(i)</b>	1	2
i) A change in the amount of fat in your legs?	1	2 <b>(j)</b>	1	2
j) A change in the amount of fat in your buttocks?	1	2 <b>(B13)</b>	1	2

B13. Now I am going to ask you about actions you may have intentionally taken to change or maintain the shape of your body. Since your (MONTH) study visit, have you taken any of the following actions to influence your body shape or fat distribution:

	<u>YES</u>	<u>NO</u>
a. changed your diet? .....	1	2
b. changed your exercise habits?.....	1	2
c. had cosmetic surgery, including implants, injections, liposuction, or surgical removal of fat? .....	1	2
d. had weight-related surgery, including gastric bypass, or gastric stapling? .....	1	2

**SECTION C: MEDICAL CONDITIONS AND CONCOMITANT ILLNESSES/SYMPTOMS**

For the following questions, I am going to use the words “health care provider” to mean any doctor, nurse, physician’s assistant or nurse practitioner you go to for medical care.

**PROMPT: IF PARTICIPANT RESPONDS “YES” TO ANY SECTION C ANSWERS THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS AND OBTAIN MEDICAL RECORD RELEASE.**

C1. a. Since your (MONTH) study visit, have you been told by a health care provider that you had cervical cancer?

**YES**.....1  
 NO.....2 (C2)

b. Have you had surgery (been admitted to the hospital and had surgery in an operating room) to treat the cervical cancer?

YES..... 1  
 NO..... 2

c. Have you had a CAT or MRI scan of your abdomen (a big donut-shaped machine that takes special pictures)?

YES..... 1  
 NO..... 2

d. Have you been told that you need to have either surgery or radiation therapy?

YES..... 1  
 NO..... 2

C2. Since your (MONTH) study visit, have you been told by a health care provider that you had any other type of cancer, including skin cancer, lymphoma, Kaposi’s sarcoma, Hodgkin’s disease, breast cancer or cancer of the female organs – the ovaries or uterus?

YES..... 1  
 NO..... 2 (C13)

What kind of cancer? Was it: **[READ C3 - C12]**

	<u>YES</u>	<u>NO/NEVER HEARD OF IT</u>
C3. Breast cancer.....	<b>1</b>	2 (C4)

a. Have you had a lump removed by a surgeon (not a needle biopsy, but an incision resulting in stitches)?

YES.....1  
 NO.....2

b. Have you had a mastectomy (removal of entire breast)?

YES.....1  
 NO.....2

WIHS ID#

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What kind of cancer? Was it: **[READ C3 - C12]**

	<u>YES</u>	<u>NO/NEVER HEARD OF IT</u>
C4. Cancer of the ovary .....	1	2
C5. Cancer of the uterus .....	1	2
C6. Kaposi's Sarcoma (KS) .....	1	2
C7. Lymphoma .....	1	2
C8. Lymphoma in the brain.....	1	2
C9. Hodgkin's disease .....	1	2
C10. Skin cancer (not KS).....	1	2
C11. Cancer of the liver.....	1	2
C12. Other .....	1	2 (C13)

SPECIFY: \_\_\_\_\_

C13. PLEASE RECORD THE TOTAL NUMBER OF CANCERS REPORTED AT THIS VISIT. DO NOT FORGET TO INCLUDE CERVICAL CANCER IF REPORTED IN QUESTION C1a, IN ADDITION TO ALL CANCERS REPORTED IN QUESTIONS C3 – C12.

\_\_\_\_\_  
# CANCERS

**PROMPT: IF QUESTION C13 = 00, SKIP TO QUESTION C18.**

**START F22HXS8**

**PROMPT: FOR EACH CANCER INDICATED IN QUESTION C13, COMPLETE QUESTIONS C14–C15. THE NUMBER OF BOXES COMPLETED MUST EQUAL THE VALUE RECORDED AT C13. INDICATE THE LOCATION OF EACH REPORTED CANCER IN a, THEN COMPLETE b–f AS INDICATED FOR EACH. IF THE TOTAL NUMBER OF REPORTED CANCERS IS GREATER THAN TWO, PLEASE XEROX THIS PAGE AND INSERT THE COPY AFTER PAGE 6.**

C14. a. LOCATION OF REPORTED CANCER: \_\_\_\_\_

**PROMPT: REPLACE (LOCATION) WITH THE LOCATION WRITTEN IN C14a.**

Now I'm going to ask you a few more questions about your (LOCATION) cancer diagnosis.      YES      NO

b. Is this your first diagnosis of cancer? ..... 1 (c)      2 (e)

c. When your (LOCATION) cancer diagnosis was made, were you told that it had also metastasized or spread to another part of your body?..... 1 (d)      2 (C15)

d. Spread to where? \_\_\_\_\_ (C15)

e. Were you told that the cancer you are now reporting had metastasized or spread from the original cancer? ..... 1 (f)      2 (f)

f. Where was the original cancer? \_\_\_\_\_ (C15)

WIHS ID#

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C15. a. LOCATION OF REPORTED CANCER: \_\_\_\_\_

**PROMPT: REPLACE (LOCATION) WITH THE LOCATION WRITTEN IN C15a.**

Now I'm going to ask you a few more questions about your (LOCATION) cancer diagnosis. YES NO

b. Is this your first diagnosis of cancer? ..... 1 (c) 2 (e)

c. When your (LOCATION) cancer diagnosis was made, were you told that it had also metastasized or spread to another part of your body?..... 1 (d) 2 (C16)

d. Spread to where? \_\_\_\_\_ (C16)

e. Were you told that the cancer you are now reporting had metastasized or spread from the original cancer? ..... 1 (f) 2 (f)

f. Where was the original cancer? \_\_\_\_\_ (C16)

**END F22HXS8 .**

**PROMPT: IF ANY OF C1–C12 = YES, THEN COMPLETE ASCERTAINMENT TRACKING CHECKLIST (ATC) FOR EACH ILLNESS AND OBTAIN MEDICAL RECORD RELEASE. ALSO, IF EITHER C14c/C15c OR C14e/C15e = YES, THEN COMPLETE ATC FOR METASTATIC CANCER.**

C16. Since your (MONTH) study visit have you received cancer chemotherapies? YES NO  
1 2

C17. Since your (MONTH) study visit have you received radiation treatments? 1 2

C18. Since your (MONTH) study visit, have you had a new diagnosis of asthma, or a worsening of your asthma?

YES..... 1  
NO..... 2

C19. The next few questions are about tuberculosis. I will refer to tuberculosis as TB for short. Since your (MONTH) study visit, as far as you know, has anyone in your family or anyone you lived with, had TB?

YES..... 1  
NO..... 2

C20. Since your (MONTH) study visit, have you had TB?

**YES..... 1**  
NO..... 2 (C21)



b. Has a health care provider **ever** told you that you had osteopenia or osteoporosis or low bone mineral density (that is, thinning or weakening bones)?

YES ..... 1  
 NO..... 2

c. Since your (MONTH) study visit, has a health care provider told you that you had broken or fractured any of your bone(s)? This could include your spine, hip, arm, or any other bone.

YES ..... 1  
 NO..... 2 (C34)

C33. Since your (MONTH) study visit, has a health care provider told you that you had broken or fractured...

	<u>YES</u>	<u>NO</u>
a. Your hip?.....	1	2 (b)
2. Did that fracture occur....		
i. As a result of a fall from standing height or less .....	1 (b)	2
ii. Because of a harder fall.....	1 (b)	2
iii. From a car accident or other severe trauma .....	1 (b)	2
iv. Don't know.....	1	2
b. Your wrist (not including forearm or hand)? .....	1	2 (c)
2. Did that fracture occur....		
i. As a result of a fall from standing height or less .....	1 (c)	2
ii. Because of a harder fall.....	1 (c)	2
iii. From a car accident or other severe trauma .....	1 (c)	2
iv. Don't know.....	1	2
c. Your spine?.....	1	2 (d)
2. Did that fracture occur....		
i. As a result of a fall from standing height or less .....	1 (d)	2
ii. Because of a harder fall.....	1 (d)	2
iii. From a car accident or other severe trauma .....	1 (d)	2
iv. Don't know.....	1	2
d. Any other bone? .....	1	2 (C34)
1. SPECIFY LOCATION: _____		
2. Did that fracture occur....		
i. As a result of a fall from standing height or less .....	1 (C34)	2
ii. Because of a harder fall.....	1 (C34)	2
iii. From a car accident or other severe trauma .....	1 (C34)	2
iv. Don't know.....	1	2



C34. Since your (MONTH) study visit, were you diagnosed with liver disease?

- YES ..... 1
- NO..... 2 (C35)

a. Since your (MONTH) study visit, were you diagnosed with “fatty liver,” or a build-up of fat in the liver cells?

- YES ..... 1
- NO..... 2

b. (Since your (MONTH) study visit, were you diagnosed with) alcoholic liver damage?

- YES ..... 1
- NO..... 2

c. (Since your (MONTH) study visit, were you diagnosed with) cirrhosis?

- YES ..... 1
- NO..... 2 (d)

These are other conditions that can be a consequence of liver cirrhosis.

i. Since your (MONTH) study visit, have you had abnormal fluid in the belly (ascites)?

- YES ..... 1
- NO..... 2

ii. (Since your (MONTH) study visit, have you had) bleeding from enlarged veins in your esophagus or stomach (varices)?

- YES ..... 1
- NO..... 2

iii. (Since your (MONTH) study visit, have you had) hepatic encephalopathy (confusion or decreased awareness caused by liver disease)?

- YES ..... 1
- NO..... 2

d. Since your (MONTH) study visit, have you been tested for liver cancer?

- YES ..... 1
- NO..... 2 (C35)

i. Did you have a blood test to look for liver cancer (called AFP or alpha-fetoprotein)?

- YES ..... 1
- NO..... 2

ii. Did you have an ultrasound or CT (CAT) scan to look for liver cancer?

- YES ..... 1
- NO..... 2

C35. Since your (MONTH) study visit, have you had a new diagnosis of hepatitis C?

- YES..... 1  
 NO ..... 2 (C38)

C36. c. Has anyone offered you treatment for hepatitis C since your (MONTH) study visit?

- YES..... 1  
 NO ..... 2

C38. Since your (MONTH) study visit, have you had a liver biopsy for any reason?

- YES.....  ..... 1  
 NO ..... 2 (C39)

a. Why did you have the liver biopsy?

- To see how much hepatitis C has affected your liver..... 1  
 It was recommended by your doctor for another reason ..... 2  
 As part of a research study ..... 3  
 Other reason..... 4

SPECIFY: \_\_\_\_\_

**PROMPT: IF C38 = YES, THEN COMPLETE ASCERTAINMENT TRACKING CHECKLIST AND OBTAIN MEDICAL RECORD RELEASE.**

C39. Have you been told by a health care provider that you needed a liver transplant since your (MONTH) study visit?

- YES..... 1  
 NO ..... 2 (C42)

C40. Have you had a liver transplant since your (MONTH) study visit?

- YES..... 1  
 NO ..... 2

C41. Are you currently on a waiting list for a liver transplant?

- YES..... 1  
 NO ..... 2

C42. Since your (MONTH) study visit, has a health care provider told you that you had...

	<u>YES</u>	<u>NO</u>	<u>DON'T KNOW</u>
a. A new diagnosis of angina or chest pain related to heart disease .....	1	2 (b)	<-8> (b)
i. Were you hospitalized for angina or chest pain due to heart disease? .....	<input type="text" value="1"/>	2	<-8>
b. A new diagnosis of congestive heart failure or CHF .....	1	2 (c)	<-8> (c)
i. Were you hospitalized for congestive heart failure? .....	<input type="text" value="1"/>	2	
c. A heart attack or myocardial infarction or MI .....	<input type="text" value="1"/>	2	<-8>
d. A stroke or CVA .....	<input type="text" value="1"/>	2	<-8>
e. A transient ischemic attack or TIA or "mini-stroke" .....	<input type="text" value="1"/>	2	<-8>

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C44. Since your (MONTH) study visit, have you had any surgery or procedure to look for or to open blocked vessels in your heart or other areas of your body? (PROBE: Your doctor may have called this: cardiac catheterization, percutaneous revascularization, PTCA, angioplasty, stenting, carotid endarterectomy, surgical revascularization, CABG, or coronary artery bypass grafting.)

YES ..... 1
NO ..... 2 (C45)

Was this procedure or surgery done on: YES NO

a. Your heart vessels? ..... 1 2 (b)

i. What was done? \_\_\_\_\_

b. Other vessels? ..... 1 2 (C45)

i. What was done? \_\_\_\_\_

C45. Do you take aspirin three days or more of every week?

YES ..... 1
NO ..... 2

PROMPT: IF ANY OF C42ai, C42bi, C42c, C42d, C42e OR C44a = YES, THEN COMPLETE ASCERTAINMENT TRACKING CHECKLIST.

C46. Since your (MONTH) study visit, have you had a serious head injury – that is, had an injury to your head, scalp, or brain? (PROBE: A serious head injury may also be associated with dizziness, confusion, pain that lasts after the injury, a loss of consciousness, or needing a hospital visit.)

YES ..... 1
NO ..... 2 (SECTION D)

a. How many head injuries have you had? [ ][ ][ ] # HEAD INJURIES START F22HXS10

PROMPT: FOR EACH HEAD INJURY INDICATED IN QUESTION C46a, COMPLETE QUESTIONS C47a-g. THE NUMBER OF SUBFORMS COMPLETED MUST EQUAL THE VALUE RECORDED AT C46a. IF THE TOTAL NUMBER OF REPORTED HEAD INJURIES IS GREATER THAN ONE, PLEASE XEROX THIS PAGE AND INSERT THE COPY AFTER PAGE 13.

C47. Now I'd like to ask some questions about each of these injuries. Let's start with the earliest one.

a. How did it happen?

- Had a fall and hit head..... 1
Car accident..... 2
Sports injury ..... 3
Physical violence..... 4
Other..... 5

SPECIFY: \_\_\_\_\_

- b. How old were you when it happened?   |\_|\_| YEARS
- |  | <u>YES</u> | <u>NO</u> |
|--|------------|-----------|
| c. Did you see a doctor because of the injury? .....                                 | 1          | 2         |
| d. Did you stay overnight in a hospital because of the injury? .....                 | 1          | 2         |
| e. Did you lose consciousness or were you “knocked out” because of the injury? ..... | 1          | 2 (f)     |
- i. How long were you unconscious? (**PROBE:** How many minutes?)
- |       |               |   |
|-------|---------------|---|
| _ _ _ | MINUTES ..... | 1 |
|       | HOURS .....   | 2 |
|       | DAYS .....    | 3 |
- |   | <u>YES</u> | <u>NO</u> |
|---|------------|-----------|
| f. Did you have a skull fracture? .....                                     | 1          | 2         |
| g. Did you have a seizure or fit within 7 days after the head injury? ..... | 1          | 2         |

**END F22HXS10** .

### SECTION D: SKIN AND ORAL CONDITIONS

**ASK QUESTIONS D1 AND D3 FOR EACH CONDITION BELOW. EACH TIME A PARTICIPANT RESPONDS THAT SHE HAS HAD THE CONDITION, ASK SUBQUESTION “a” BEFORE PROCEEDING TO THE NEXT CONDITION.**

D1-D3

Since your (MONTH) study visit, has a health care provider, either a doctor, dentist, nurse practitioner, nurse, or physician’s assistant, told you that you had **(CONDITION)?**

D1a –D3a

How many different times in the past 6 months did you have this?

- |  |                                      |                     |
|--|--------------------------------------|---------------------|
| D1. Shingles (Herpes Zoster)?  | YES..... 1<br>NO ..... 2 <b>(D3)</b> | a.  _ _ <br># TIMES |
| b. Have you had 2 or more separate areas with shingles at the same time? | YES..... 1<br>NO ..... 2             |                     |
| D3. Candida or thrush, yeast inside your mouth?                          | YES..... 1<br>NO ..... 2 <b>(E0)</b> | a.  _ _ <br># TIMES |

### SECTION E: AIDS DEFINING ILLNESSES

E0. PARTICIPANT’S CURRENT HIV STATUS:

- |                |                |
|----------------|----------------|
| POSITIVE ..... | 1              |
| NEGATIVE ..... | 2 <b>(E22)</b> |

We are now interested in finding out about diseases that some women, especially those with HIV, can experience. Many of the terms in this section are very technical and you may not have heard of them. If you’ve never heard of a term just say so.

E1. Since your (MONTH) study visit, has a health care provider told you that you had a CD4 count (T-cell count) less than 200 or less than 14%?

YES..... 1  
 NO/NEVER HEARD OF IT ..... 2

E2. (Since your (MONTH) study visit), has a health care provider told you that you had herpes simplex with ulcers or sores lasting longer than one month?

YES..... 1  
 NO/NEVER HEARD OF IT ..... 2

E3. (Since your (MONTH) study visit), have you had diarrhea (3 or more soft or liquid stools per day) that lasted for more than one month?

YES..... 1  
 NO ..... 2 (E5)

E4. (Since your (MONTH) study visit), has a health care provider told you that any diarrhea you may have had was caused by:

	<u>YES</u>	<u>NO/NEVER HEARD OF IT</u>
i. Cryptosporidia?	1	2
ii. Microsporidia?	1	2
iii. Isospora?	1	2
iv. C-M-V?	1	2
v. M-A-I?	1	2

E5. (Since your (MONTH) study visit), has a health care provider told you that you had herpes simplex infection of the lungs or esophagus, (the tube between your mouth and your stomach)?

YES..... 1  
 NO/NEVER HEARD OF IT ..... 2

E6. (Since your (MONTH) study visit), has a health care provider told you that you had PCP, pneumocystis carinii pneumonia?

YES..... 1  
 NO/NEVER HEARD OF IT ..... 2

E7. (Since your (MONTH) study visit), has a health care provider told you that you had another type of pneumonia, lung infection? Do not answer yes if you were diagnosed only with bronchitis.

YES..... 1  
 NO/NEVER HEARD OF IT ..... 2 (E8)

**PROMPT: IF PARTICIPANT RESPONDS “YES” TO ANY OF QUESTIONS E4-20 THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS.**

WIHS ID#

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- a. In the past 12 months, how many times has a health care provider told you that you had pneumonia that required antibiotics, not counting PCP? |\_|\_|  
# TIMES
- b. Since your (MONTH) study visit, how many times have you had pneumonia that required antibiotics, not counting PCP? |\_|\_|  
# TIMES
- c. When was the last time you had pneumonia, not counting PCP? |\_|\_|\_|/|\_|\_|\_|\_|\_|  
M M Y Y Y Y  
I need the month and the year?

E8. (Since your (MONTH) study visit, has a health care provider told you that you had) Candida or thrush, a yeast infection of the esophagus (the tube between your mouth and stomach) not just in your mouth?

**YES**..... 1  
**NO/NEVER HEARD OF IT** ..... 2

E9. (Since your (MONTH) study visit, has a health care provider told you that you had) Candida or thrush, a yeast infection of the lungs or airways (trachea or bronchi)?

**YES**..... 1  
**NO/NEVER HEARD OF IT** ..... 2

E10. (Since your (MONTH) study visit, has a health care provider told you that you had) an M-A-I infection, which is sometimes called M-A-C or MAC?

**YES**..... 1  
**NO/NEVER HEARD OF IT** ..... 2

E11. (Since your (MONTH) study visit, has a health care provider told you that you had) Toxo infection, or toxoplasmosis of the brain?

**YES**..... 1  
**NO/NEVER HEARD OF IT** ..... 2

E12. (Since your (MONTH) study visit, has a health care provider told you that you had) C-M-V, cytomegalovirus:

	<b>YES</b>	<b>NO</b>
a. in either eye (retinitis)? .....	<b>1</b>	2
b. in your blood? .....	<b>1</b>	2
c. in your intestine? .....	<b>1</b>	2
d. in your liver? .....	<b>1</b>	2
e. elsewhere in your body?.....	<b>1</b>	2 <b>(E13)</b>

SPECIFY: \_\_\_\_\_

E13. Since your (MONTH) study visit, has a health care provider told you that you had meningitis related to HIV?

**YES**..... 1  
**NO/NEVER HEARD OF IT** ..... 2 **(E14)**

**PROMPT: IF PARTICIPANT RESPONDS “YES” TO ANY OF QUESTIONS E4-20 THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS.**

WIHS ID#

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a. Were you told that this was Crypto, Cryptococcal meningitis?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2

E14. (Since your (MONTH) study visit, has a health care provider told you that you had) Cryptococcal infection:

	<u>YES</u>	<u>NO</u>
a. in your blood?.....	1	2
b. elsewhere in your body?.....	1	2 (E15)

SPECIFY: \_\_\_\_\_

E15. (Since your (MONTH) study visit, has a health care provider told you that you had) Histoplasmosis infection or Histo?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2 (E16)

a. Where in your body? SPECIFY: \_\_\_\_\_

E16. (Since your (MONTH) study visit, has a health care provider told you that you had) Cocci, coccidioidomycosis infection or Valley Fever?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2

E17. (Since your (MONTH) study visit, has a health care provider told you that you had) wasting syndrome, in other words, severe weight loss?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2 (E18)

Have you had (CONDITION) that lasted for at least one month, during the same time that you experienced severe weight loss?

	<u>YES</u>	<u>NO</u>
a. chronic diarrhea (at least 3 loose stools per day for greater than or equal to 30 days?)	1	2
b. chronic weakness and documented fever (for greater than or equal to 30 days?)	1	2
c. were you told that [this symptom/these symptoms] [was/were] due to HIV/AIDS?	1	2

E18. (Since your (MONTH) study visit, has a health care provider told you that you had) dementia or encephalopathy, or that you had a memory problem or confusion caused by HIV?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2

**PROMPT: IF PARTICIPANT RESPONDS “YES” TO ANY OF QUESTIONS E4-20 THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS.**

WIHS ID#

[Empty box for WIHS ID#]

E19. (Since your (MONTH) study visit, has a health care provider told you that you had) an infection in the blood with a bacteria called salmonella?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2 (E20)

a. Have you had this more than once, since your (MONTH) study visit?

YES..... 1  
NO ..... 2

E20. (Since your (MONTH) study visit, has a health care provider told you that you had) PML, progressive multifocal leukoencephalopathy, a disease of the brain?

YES..... 1  
NO/NEVER HEARD OF IT ..... 2

**PROMPT: IF PARTICIPANT RESPONDS “YES” TO ANY OF QUESTIONS E4-20 THAT HAVE BEEN SHADED IN GRAY, COMPLETE AN ATC FOR EACH ILLNESS.**

E21. (Since your (MONTH) study visit, has a health care provider told you that you had) AIDS?

YES..... 1  
NO ..... 2

E22. Since your (MONTH) study visit, have you had a biopsy? A biopsy is when tissue, sometimes a lump or a mass, is removed with a needle or by making an incision. (DO NOT include biopsies that have been taken at WIHS gynecologic exams, including WIHS colposcopic examinations.)

YES..... 1  
NO ..... 2 (E23)

Where in your body? Was it a:

	<u>YES</u>	<u>NO</u>
a. Lung biopsy?	1	2
b. Skin biopsy?	1	2
c. Bone marrow biopsy?	1	2
d. Cervical biopsy?	1	2
e. Uterine or endometrial biopsy?	1	2
f. Breast biopsy?	1	2
g. Other biopsy, not previously mentioned?	1	2

SPECIFY: \_\_\_\_\_

**PROMPT: IF THE PARTICIPANT RESPONDED “YES” TO ANY OF QUESTIONS E22a–g, COMPLETE AN ACSR ATC FOR EACH REPORTED BIOPSY AND OBTAIN MEDICAL RECORD RELEASE.**



WIHS ID#

E23. Since your (MONTH) study visit, 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.

YES..... 1  
NO ..... 2 (E25)

a. How many times since your (MONTH) study visit? |\_|\_|  
# TIMES

b. Did you continue taking your antiretroviral medications while you were hospitalized?

YES..... 1  
NO ..... 2  
NOT APPLICABLE..... 3

E24. Which of the following best describes the reason(s) you were hospitalized?

Were you hospitalized for:	<u>YES</u>	<u>NO</u>	
a. Childbirth .....	1	2	
b. An injury or accident.....	1	2	
c. Elective surgery (for example, hernia repairs, cosmetic surgery, joint replacement) .....	1	2	
d. Non-elective surgery (for example, emergency surgery, heart surgery, surgeries for cancer or precancerous conditions) .....	1	2	
e. A psychiatric or mental health problem .....	1	2	
f. A medical illness (for example, infections, heart problems, stomach or intestinal problems) .....	1	2	(g)

What best describes the reason(s) you were hospitalized?

i. Heart problems.....	1	2	
ii. Stomach or intestinal problems.....	1	2	
iii. Liver problems .....	1	2	
iv. Pneumonia.....	1	2	
v. An infection other than pneumonia.....	1	2	
vi. A lung problem other than pneumonia, such as asthma.....	1	2	
vii. Another reason .....	1	2	(g)

SPECIFY: \_\_\_\_\_

g. Any other reason .....

SPECIFY: \_\_\_\_\_

E25. TIME MODULE ENDED |\_|\_| : |\_|\_| AM..... 1  
PM..... 2