### Abbreviated Telephone Interview

Administer this questionnaire when the participant is unable or unwilling for any reason to complete an Section 4 interview questionnaire as part of his 6 month study visit. This form can be conducted over the phone or in person. Obtain a Medical Release for any diagnoses that qualify as a reportable medical outcome. Refer to the corresponding questions in the Section 4 guidelines for instructions and codes.

1. Let's start with some medical conditions. Since your last visit [in (MONTH, YEAR)], were you diagnosed with some form of cancer, including Kaposi’s sarcoma, non-Hodgkin’s lymphoma, primary brain lymphoma, or Castleman’s disease?

   a) IF YES: Where in the body was the cancer (Castleman’s disease) and what kind of cancer did they say it was?

   b) In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?

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<thead>
<tr>
<th>Site</th>
<th>Type</th>
<th>Code</th>
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</table>

   (1) Site: ________________________________
      Type: ________________________________
      Date: ___ ___ / ___  ___  ___  ___
      M    M      Y    Y     Y     Y

   (2) Site: ________________________________
      Type: ________________________________
      Date: ___ ___ / ___  ___  ___  ___
      M    M      Y    Y     Y     Y

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

      Name of hospital/clinic or doctor
      ________________________________

      Address
      ________________________________

      City State
      ________________________________

2. Since your last visit [in (MONTH, YEAR)], were you diagnosed with any AIDS-related illnesses other than Kaposi’s sarcoma, non-Hodgkin’s lymphoma or primary brain lymphoma?

   a) IF YES: What was the diagnosis?

   b) In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?

   (1) Diagnosis: ________________________________
       AIDS Code: ___ ___ ___ ___
(2) Diagnosis: ____________________________________________

__________________________
AIDS Code: ___ ___ ___ ___

(3) Diagnosis: ____________________________________________

__________________________
AIDS Code: ___ ___ ___ ___

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

________________________________________________________________________
Name of hospital/clinic or doctor

________________________________________________________________________
Name of hospital/clinic or doctor

________________________________________________________________________
Address

________________________________________________________________________
Address

________________________________________________________________________
City State

________________________________________________________________________
City State

3. Since your last visit [in (MONTH, YEAR)], have you been admitted to the hospital for any reason? This includes overnight stays and outpatient procedures.

☐ No → SKIP TO Q4

☐ Yes → How many separate times were you a patient in a hospital since your last visit [in (MONTH, YEAR)]

___ ___ times

GET MEDICAL RELEASE FOR POTENTIAL REPORTABLE OUTCOMES

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

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

___ ___ / ___ ___ ___ ___ ___ ___ ___ ___
M M D D Y Y Y Y

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

___ ___ NIGHTS

IF OUTPATIENT: FILL IN ZERO.

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

________________________________________________________________________
Diagnosis

________________________________________________________________________
ICD9 Code

________________________________________________________________________
Diagnosis

________________________________________________________________________
ICD9 Code
### NOTE NAME AND ADDRESS OF HOSPITAL

Name of hospital or clinic  
Address  
City  
State  

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

______ / ______ / ______ / ______ / ______ / ______ / ______ / ______ / ______

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

______ NIGHTS

IF OUTPATIENT: FILL IN ZERO.

c. For what condition or problem were you hospitalized?

RECORD FULLY IN R’S OWN WORDS.

______________________________  __________  __________  __________  
Diagnosis  

______________________________  __________  __________  __________  
Diagnosis  

### GET MEDICAL RELEASE FOR POTENTIAL REPORTABLE OUTCOMES

NOTE NAME AND ADDRESS OF HOSPITAL

Name of hospital or clinic  
Address  
City  
State  

d. Did you have another prior hospitalization/outpatient procedure since your last visit [in MONTH, YEAR]?  

<table>
<thead>
<tr>
<th>Date</th>
<th>Diagnosis</th>
<th>ICD9 Code</th>
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AbbreviatedTelephoneInterview.wpd  March 15, 2006
GET MEDICAL RELEASE FOR POTENTIAL REPORTABLE OUTCOMES
NOTE NAME AND ADDRESS OF HOSPITAL

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4. (1) Since your visit [in (MONTH, YEAR)], have you had any biopsies of the skin, anus, rectal area or other tissues and organs? By a biopsy, we mean removal of any tissue or gland to study under a microscope.

- [ ] Yes
- [x] No → GO TO Q5

(2) How many times have you had a biopsy since your last visit [in (MONTH, YEAR)]

___ TIMES

(3) For each biopsy, please tell me:

<table>
<thead>
<tr>
<th>a) Where in the body?</th>
<th>b) What did they say the diagnosis or result of the biopsy was?</th>
<th>c) Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy.</th>
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</thead>
<tbody>
<tr>
<td>Site code: __ __</td>
<td>Tissue diagnosis code: __</td>
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<tr>
<td>Name of doctor</td>
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<td>Name of hospital/clinic</td>
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<td>City</td>
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</tbody>
</table>

2. __________________________________________________________________________

Site code: __ __ Tissue diagnosis code: __                                                                                                          City State
5. I am now going to ask you about other conditions, ailments or disorders. Were you diagnosed with any of the following since your last visit [in (MONTH, YEAR)]? This includes new episodes or recurrences of chronic conditions.

GET RELEASE TO REQUEST MEDICAL RECORDS

(1) Angina or chest pain caused by your heart  ○ Yes  ○ No
(2) Heart attack or myocardial infarction (MI)  ○ Yes  ○ No
(3) Congestive heart failure or CHF  ○ Yes  ○ No
(4) Stroke or cerebrovascular accident (CVA)  ○ Yes  ○ No
(5) Mini-strokes or transient ischemic attacks (TIA)  ○ Yes  ○ No
(6) Too fast, too slow, or irregular heart beat  ○ Yes  ○ No
(7) Any blood vessels (arteries) that were blocked or closed  ○ Yes  ○ No
(8) An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas  ○ Yes  ○ No
(9) A blood clot in your legs  ○ Yes  ○ No
(10) A blood clot in your lungs  ○ Yes  ○ No
(11) Seizure or convulsions  ○ Yes  ○ No
(12) Osteoporosis (bone thinning)  ○ Yes  ○ No
(13) Avascular necrosis (osteonecrosis) or weakness or degeneration of your bones, especially hips or knees, not due to arthritis  ○ Yes  ○ No
(14) Kidney disease/Renal failure  ○ Yes  ○ No

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

Name of hospital/clinic or doctor
Name of hospital/clinic or doctor
Address
Address
City State
City State
Date of diagnosis
Date of diagnosis
6. Since your last visit [in (MONTH, YEAR)], have you had any neurological evaluation or a physical examination to look for problems of the nervous system (brain, spinal cord, nerves in hands and feet)?

   IF YES: Was there a diagnosis for your condition?

   IF YES: What was the diagnosis?

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

7. Since your last visit [in (MONTH, YEAR)], have you seen a doctor or other medical practitioner for any OTHER NEW conditions or problems we did not ask you about?

   a) Was there a diagnosis?
   b) What was the diagnosis
   c) ICD9 Code

   1) O Yes O No ______________________ ______________________ ______________________
   2) O Yes O No ______________________ ______________________ ______________________
   3) O Yes O No ______________________ ______________________ ______________________
   4) O Yes O No ______________________ ______________________ ______________________
   5) O Yes O No ______________________ ______________________ ______________________
8. Please tell me what drugs and medications that you have taken, including prescribed medications for HIV and other illnesses, over the counter medications, and other medications you took on your own since your last visit [in (MONTH, YEAR)]?

<table>
<thead>
<tr>
<th></th>
<th>a) Drug Code</th>
<th>b) When specified, what was the name of the (KIND OF DRUG) you took?</th>
<th>c) What did you take this drug for?</th>
<th>d) Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</th>
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<td>○ Yes ○ No</td>
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9. Is there anything else you think we should know about?  
   ○ Yes  ○ No  
   Specify:
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________
   __________________________________________