

PWA Short Telephone Interview

ID #: **MACSID_##** _____

Date: ____ / ____ / ____ **PWDTM_##**
PWDTD_##
PWDTY_##

If contact was established but participant unable or unwilling to complete the questionnaire, check here: _____

Visit #: **VISIT_##** _____

1. **Has your address changed since your last contact with us? Yes No**
If yes, what is your new address?

2. **Have you had any serious illness(es) or significant symptoms since your last contact with us? If YES, briefly describe all illnesses below. Details are especially helpful on any AIDS diagnoses, cancer or neurologic conditions:**

Illness/Symptoms	MM	DD	YY	ICD - 9

3. **At any time (since your last visit in [Month]) did you stay overnight as a patient in a hospital? Yes No**
HOSPL_##

4. **Name and address of the doctor and/or hospital that we may contact for further information: (Any information that you provide will be helpful.)**

Dr. Name:	Telephone:
Address:	City:
Hospital/Address:	City:
Admission Dates:	

5. **Do you have any kind of health insurance coverage or Medical Assistance? Yes No INSUR_##**

a) Coverage by an HMO	Yes	HMOC_##
b) Private Insurance (Blue Cross, CIGNA, etc.) (not an HMO)	Yes	GPIC_##
c) Individual Private Insurance (Blue Cross, CIGNA, etc.) (not an HMO)	Yes	IPIC_##
d) Medicaid, Medi-Cal or Medical Assistance	Yes	MCAID_##
e) Medicare (for people over 65 or permanently disabled)	Yes	MCARE_##
f) Health care benefits from the Armed Forces or Veteran's Administration	Yes	VABEN_##
g) CHAMPUS or CHAMP-VA - medical insurance for dependents of military personnel or survivors or disabled veterans.	Yes	CHAMP_##
h.) ADAP drugs assistance plan	Yes	ADAPP_##
i) Other:	Yes	OTHER_##

Note: We will be sending you a medical records release form to sign. It is especially important to have a current one for our participants who have experience a recent illness. We hope you will return it to us as soon as possible. Thank you!