1. Let's start with a list of medical conditions. Since your last visit [in \( \text{MONTH, YEAR} \)], were you diagnosed with any of the following? How about \( \text{EACH} \)?

<table>
<thead>
<tr>
<th>IF &quot;NO&quot; TO ( \text{B} ) GO TO NEXT ROW</th>
<th>In what month and year (since your last visit), was it [first] diagnosed?</th>
<th>How many times were you diagnosed with this since your last visit? FOR 9 OR MORE TIMES CODE &quot;9&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>A. Kaposi's sarcoma or KS</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} )</td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} )</td>
</tr>
<tr>
<td><strong>KAPOS_39</strong></td>
<td>( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>B. Pneumocystis carinii pneumonia (PCP)</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>PCP_39</strong></td>
<td>( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>C. Other pneumonia, specify</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>PNEOM_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>D. Toxoplasmosis or Toxo infection</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>TOXOP_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>E. Cytomegalovirus infection (CMV)</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>CMVE_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>CMVC_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>CMVL_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>CMVO_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>F. Mycobacterial infection (MAC, MAI or atypical TB)</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
<tr>
<td><strong>MAI_39</strong></td>
<td>( \text{NO} ) ( \text{YES} ) ( \text{GO TO NEXT ROW} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} ) ( \text{NO} ) ( \text{YES} )</td>
<td></td>
</tr>
</tbody>
</table>
1. Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>H. Meningitis related to HIV or cryptococcal meningitis</td>
<td>LYMP_39</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>I. Candida or thrush, a yeast infection of the esophagus, not just your mouth</td>
<td>CANM_39</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>J. Cryptosporidiosis</td>
<td>CRYSM_39</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>K. Wasting Syndrome or severe weight loss</td>
<td>WSNM_39</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
</tbody>
</table>

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

- Name of hospital/clinic or doctor:
- Address:
- City:
- State:

2. [Since your last visit in (MONTH)] In addition to these diagnoses, has a doctor or medical practitioner told you that you have had any other AIDS conditions? Go to Q 50.B to record the name and address of the physician who diagnosed the condition(s).

- No
- Yes

IF “YES”: What was the diagnosis?

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Options</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADX1M_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>ADX1Y_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>ADX2M_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>ADX2Y_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>ADX3M_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
<tr>
<td>ADX3Y_39</td>
<td>J</td>
<td>Go to next row for YES, skip to Q3 for NO</td>
</tr>
</tbody>
</table>
3. (Since your last visit in [MONTH]) Has a doctor or medical practitioner told you that you had some form of cancer (excluding Kaposi’s sarcoma, primary brain lymphoma and non-Hodgkin’s lymphoma)?

IF "NO," GO TO Q 4

IF YES,

What kind of cancer did they say it was?

In what month and year was it first diagnosed since your last visit?

1) Type

- CAN1T_39

- CAN2T_39

For type, please write:

- CAN1M_39
- CAN1Y_39
- CAN2M_39
- CAN2Y_39

What was the name and address of the physician who diagnosed the cancer?

1) Name of hospital/clinic or doctor

2) Address

City State

The next few questions are about tuberculosis or TB for short.

4A. (Since your last visit in [MONTH]) did you have a skin test for TB, sometimes called a PPD?

If YES: When was your last test?

Was it positive?

5A. (Since your last visit in [MONTH]) have you had an active TB infection?

If YES: When was the TB in your lungs?

Was the TB in any other part of your body (other than your lungs)?

Rooted serial number:

Page 3
6.A. [Since your last visit in (MONTH)] Have you been hospitalized overnight?
- No
- Yes

How many separate times did you stay overnight as a patient in a hospital (since your visit in (MONTH))? [NHS]\_39

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?

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

For what condition or problem were you hospitalized and the name/address of the hospital?

RECORD FULLY IN R's OWN WORDS.

6.B. c. For what condition or problem were you hospitalized and the name/address of the hospital?

IF AIDS RELATED, CODE IN QUESTIONS 1–3 AS APPROPRIATE

7. Since your last visit, have you been hospitalized, prescribed medication, or consulted a mental health professional for treatment of depression?

- No
- Yes
- Don’t know

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

Have any members of your immediate blood-related family ever been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?

- No
- Yes
- Don’t know
8.B. Have any members of your immediate family ever suffered from (EACH)?

<table>
<thead>
<tr>
<th>Condition</th>
<th>NO</th>
<th>YES</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High Cholesterol/Lipids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. High Blood Sugar/Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Chest Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Heart Attack Before 60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Broken Hip Before 60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Pancreatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Specify:**

8.A. [Since your visit in (MONTH)] Have you had a biopsy?
(By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

- NO
- YES

9.A. Have any members of your immediate family ever suffered from (EACH)?

1. High Cholesterol/Lipids
2. High Blood Sugar/Diabetes
3. High Blood Pressure
4. Stroke
5. Chest Pain
6. Heart Attack Before 60
7. Broken Hip Before 60
8. Pancreatitis
9. Cancer

**Specify:**

8.B. Have any members of your immediate family ever suffered from (EACH)?

- NO
- YES

9.A. [Since your visit in (MONTH)] Have you had a biopsy?
(By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

- NO
- YES

B. How many times have you had a biopsy [since your last visit in (MONTH)]?

**Specify:** TIMES

C. For each biopsy, please tell me:

1. Where in your body?
2. What did they say the diagnosis or result of the biopsy was?
3. Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?

**Specify:**

1) Specify
2) Specify
3) Specify

**Specify:**

1) Specify
2) Specify
3) Specify
10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

A. Shingles (or herpes zoster)
   IF YES: Which month and year (since your last visit) did this episode of shingles (zoster) begin?

B. Thrush (yeast in your mouth)
   IF YES: Which month and year (since your last visit) did this episode of thrush begin?

C. Infectious mononucleosis
D. Sinusitis, a sinus infection that requires antibiotics
E. Bronchitis
F. Pancreatitis
G. Prostate Problems
H. High blood pressure or hypertension
I. Injury to head with loss of consciousness
J. Chest pain or angina
K. Heart attack
L. Congestive heart failure or CHF
M. Stroke or CVA
N. Seizure
O. Osteoporosis (bone thinning)
P. Arthritis
   IF YES: Was it: Rheumatoid Arthritis, or degenerative Arthritis?

Q. Avascular necrosis, osteonecrosis, or had a hip replacement
R. Kidney disease/Renal failure

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? Hepatitis B or serum hepatitis? Hepatitis C?

T. Liver disease
   GET MEDICAL RELEASE

U. [Since your last visit in (MONTH)] Have you received an injection of pneumococcal vaccine/Pneumovax?

V. [Since your last visit in (MONTH)] Have you received an injection of hepatitis B vaccine or combination of A and B vaccine (Twinrix)?

W. [Since your last visit in (MONTH)] Have you received an injection of hepatitis A vaccine or combination of A and B vaccine (Twinrix)?

X. [Since your last visit in (MONTH)] Has a doctor or other medical practitioner told you that you had sickle cell anemia?

Y. [Since your visit in (MONTH)] Have you had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system?
   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)?

Name of hospital/clinic or doctor
Address
City State
Date of diagnosis

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

Name of hospital/clinic or doctor
Address
City State
Date of diagnosis
Z. [Since your last visit in (MONTH)] Have you seen a doctor or other medical practitioner for any (other) conditions or problems in the following areas?

a) Eyes
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

b) Ears, Nose, Throat, Mouth
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

c) Heart
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

d) Lungs
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

e) Stomach and Intestines
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

f) Bones, Joints or Muscles
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

  Specify:

  g) Genital and Urinary
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

  Specify:

  h) Skin
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

  Specify:

  i) Nervous system
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?

  Specify:

  j) Psychological
   IF YES:
   Was there a diagnosis?
   What was the diagnosis?
3/8" spine
perf

A) Syphilis
B) Any form of gonorrhea
C) Urethral gonorrhea (clap or drip of the urinary passage)
D) Oral gonorrhea (of the mouth or throat)
E) Rectal gonorrhea (of the rectum)

IF "NO" TO (B), SKIP TO (F)
IF "NO" TO ALL FOUR, SKIP TO Q 12

11. A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, [since your visit in (MONTH)]:

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 12

B. Did the first attack of herpes you ever had occur since your visit in (MONTH)?

C. Has there been a period [since your last visit in (MONTH)] when your (herpes) sores seemed to come more often, get worse or last longer than usual?

12. Have you had any of the following diseases or conditions [since your visit in (MONTH)]: How about (EACH)?

DISEASE OR CONDITION
HAD DISEASE
A) Syphilis
B) Any form of gonorrhea
C) Urethral gonorrhea (clap or drip of the urinary passage)
D) Oral gonorrhea (of the mouth or throat)
E) Rectal gonorrhea (of the rectum)
F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that is not caused by gonorrhea)
G) Genital warts or anal warts (condylomata acuminata)
H) Chlamydia
I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis

Specify:
13.A. [Since your visit in (MONTH)] Have you had any of the following problems or symptoms?

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>HOW ABOUT EACH?</th>
<th>Did that last for two weeks or longer?</th>
<th>And do you have that now?</th>
<th>IS THIS A NEW CONDITION? IF NO, GO TO NEXT ROW</th>
<th>WHEN BEGAN (Month and Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Persistent dizziness for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>DIZZI_39 DIZ2W_39 DIZNO_39 DIZNC_39 DIZM_39 DIZY_39</td>
</tr>
<tr>
<td>2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days</td>
<td>FATIG_39 FAT2W_39 FATIN_39 FATNC_39 FATIM_39 FATIY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Persistent or recurring fever higher than 100° for at least 3 consecutive days</td>
<td>FEVER_39 FEV2W_39 FEVRN_39 FEVNC_39 FEVRM_39 FEVRY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days</td>
<td>HEADA_39 HED2W_39 HEADN_39 HEANC_39 HEADM_39 HEADY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days</td>
<td>RASH_39 RAS2W_39 RASHN_39 RSHNC_39 RASHM_39 RASHY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days</td>
<td>GLAND_39 GLN2W_39 GLANN_39 GLANC_39 GLANM_39 GLANY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Diarrhea for at least 3 consecutive days</td>
<td>DIARR_39 DIA2W_39 DIARN_39 DIANC_39 DIARM_39 DIARY_39</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8) Drenching sweats at night on at least 3 occasions</td>
<td>SWEAT_39 SWT2W_39 SWTEN_39 SWENC_39 SWETM_39 SWETY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) Nausea, vomiting</td>
<td>VOMIT_39 VOT2W_39 VOTNO_39 VOTNC_39 VOTM_39 VOTY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) Abdominal pain, bloating, cramps</td>
<td>BLOAT_39 ABP2W_39 ABPNO_39 ABPNC_39 ABPM_39 ABPY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)</td>
<td>JDICE_39 JDI2W_39 JDINO_39 JDINC_39 JDICM_39 JDICY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13) An unusual bruise or bump or skin discoloration that lasted at least two weeks</td>
<td>BRUIS_39 BRUSN_39 BRUNC_39 BRUSM_39 BRUSY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)</td>
<td>WTLOS_39 WTLSN_39 WTLNC_39 WTLSM_39 WTLSY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15) Anemia, low RBC, low hemoglobin</td>
<td>ANEMI_39 ANENO_39 ANENC_39 ANEM_39 ANEY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 13.A. Continued

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>How about (EACH)? Did you have that at any time (since your visit in (MONTH))?</th>
<th>Did that last for two weeks or longer?</th>
<th>And do you have that now?</th>
<th>Is this a new condition? IF NO, GO TO NEXT ROW</th>
<th>In what month and year since your last visit did it begin? (IF NEEDED: Even though you don't remember the exact month, it would help if you could tell me the season or approximate time of year when it started (this last time)).</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) Unusual bleeding or bleeding that is difficult to stop</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
<td>WHEN BEGAN (Month and Year)</td>
</tr>
<tr>
<td>18) Muscle pain or weakness</td>
<td>MPAIN_39 MPW2W_39 MPWNO_39 MPWNC_39 MPWM_39 MPWY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20) Painful urination</td>
<td>PURIN_39 URN2W_39 URNNO_39 URNNC_39 URNM_39 URNY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) High blood sugar, diabetes</td>
<td>HBSUG_39 DM2W_39 DMNO_39 DMNC_39 DMM_39 DMY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>23) High cholesterol, high triglycerides or high lipids</td>
<td>HCHOL_39 CHO2W_39 CHONO_39 CHONC_39 CHOM_39 CHOY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>24) Fat maldistribution or abnormal changes in body fat</td>
<td>FATMA_39 FMD2W_39 FMDNO_39 FMDNC_39 FMDM_39 FMDY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>25) Vivid nightmares or dreams</td>
<td>DREAM_39 NVD2W_39 NVDNO_39 NVDNC_39 NVDM_39 NVDY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>26) Insomnia or problems sleeping</td>
<td>INSOM_39 IPS2W_39 IPSNO_39 IPSNC_39 IPSM_39 IPSY_39</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 13.B. [Since your last visit in (MONTH)] Have you experienced:

<table>
<thead>
<tr>
<th>If NO, go to next question. If YES, indicate severity.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severity (0= None, 1= Mild, 10= Severe)</td>
</tr>
<tr>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>1. Pain, aching, or burning in your feet or legs?</td>
</tr>
<tr>
<td>2. Pins and needles in your feet or legs?</td>
</tr>
<tr>
<td>3. Numbness (lack of feeling) in your feet or legs?</td>
</tr>
</tbody>
</table>
14. A. [Since your visit in (MONTH)] Has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs?
   - No  SKIP TO Q 15
   - Yes  RESIT_39

B. What type of test was done?
   1) Phenotype  PHENO_39
   2) Genotype  GENOT_39

C. Has your treatment (drugs) been changed as a result of that test?
   - No  RSTCH_39
   - Yes  SKIP TO Q 15.B (1)
   - Don’t know  DON’T KNOW

15. Since your last visit, have you 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 excluding acyclovir.)
   - No  MAIDS_39
   - Yes  SKIP TO Q 15.B (1)

15.A. IF NO: Why did you decide not to take HIV-related medications?
   - Not infected with HIV  NMNI_39
   - Doctor said was not necessary  NMDS_39
   - Not sick  NMNS_39
   - Too expensive  NMEX_39
   - Don’t think they work or will help  NMDW_39
   - Possible side effects  NMSE_39
   - Can’t take them the way the doctor wants (too many times during the day or won’t remember to take them)  NMCD_39
   - Other reason  NMOR_39

   SKIP TO Q 16

15.B. (1) [Since your last visit (MONTH)] Have you taken any medication or drug on this list (SHOW LIST 1 AND MEDICATION PHOTO CARDS)?
   - No  ML1AD_39
   - Yes  SKIP TO Q 15.B (3)

(2) IF NO: Why did you decide not to take HIV-related medications?
   - Doctor said was not necessary  NMDS1_39
   - Not sick  NMNS1_39
   - Too expensive  NMEX1_39
   - Don’t think they work or will help  NMDW1_39
   - Possible side effects  NMSE1_39
   - Can’t take them the way the doctor wants (pills, too many times during the day or won’t remember to take them)  NMCD1_39
   - Other reason  NMOR1_39

   SKIP TO Q 15.C

15.B. (3) Please name those drugs that you have taken or show me which ones.
   FILL IN THE BUBBLE NEXT TO THE DRUG(S).

   - 3-TC (Epivir, Lamivudine)  ML1A1_39 - ML1A2_39
   - Abacavir (Ziagen)  ML1B1_39
   - Amprenavir (Agenerase)  ML1B2_39
   - AZT (Retrovir, Zidovudine)  ML1B3_9
   - Atazanavir (BMS-232632)  ML1B4_39
   - Combivir (AZT & 3-TC)  ML1B5_39
   - d4T (Zerit, Stavudine)  ML1B6_39
   - ddI (dideoxyinosine, Didanosine, Videx)  ML1B7_39
   - Delavirdine (Rescriptor)  ML1B8_39
   - Efavirenz (Sustiva)  ML1B9_39
   - Indinavir (Crixivan)  ML1B10_39
   - Lopinavir/r (Kaletra)  ML1B11_39
   - Nelfinavir (Viracept)  ML1B12_39
   - Nevirapine (Viramune)  ML1B13_39
   - Ritonavir (Norvir)  ML1B14_39
   - Saquinavir (Invirase, Fortovase)  ML1B15_39
   - Tenofovir (Viread)  ML1B16_39
   - T-20  ML1B17_39
   - Other anti-viral from Drug List 1 (Report Acyclovir in Q16.)  ML1B18_39

   COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B(3)

15.B. (4) [Since your last visit (MONTH)], did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?
   - No  MDRUG_39
   - Yes  SKIP TO Q 15.C

   IF YES: How many times did this occur?
   MISTI_39

Did your physician prescribe or agree to any of these?
   - No  PDRUG_39
   - Yes  SKIP TO Q 15.C

For how many days did you stop during the last time?
   DDRUG_39

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B(3)
15.C. (1) [Since your last visit in (MONTH)] 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  ☐ Yes  SKIP TO Q 15.D  ML2AD_39

(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.)

☐ Atovaquone (BW566C80, Mepron)
☐ Azithromycin (Zithromax)
☐ Bactrim (Septra, SMZ-TMP, Sulfamethoxazole)
☐ Ciprofloxacin (CIPRO)
☐ Clarithromycin (Biaxin)
☐ Co-enzyme Q
☐ Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
☐ Cortisone
☐ Dapsone
☐ DHEA
☐ Ethambutol (Myambutal)
☐ Erythropoietin (Epogen, Procrit)
☐ Flagyl (metronidazole)
☐ Fluconazole (Diflucan)
☐ Ganciclovir (DHPG, Cytovene)
☐ Atovaquone (BW566C80, Mepron)
☐ Azithromycin (Zithromax)
☐ Bactrim (Septra, SMZ-TMP, Sulfamethoxazole)
☐ Ciprofloxacin (CIPRO)
☐ Clarithromycin (Biaxin)
☐ Co-enzyme Q
☐ Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
☐ Cortisone
☐ Dapsone
☐ DHEA
☐ Ethambutol (Myambutal)
☐ Erythropoietin (Epogen, Procrit)
☐ Flagyl (metronidazole)
☐ Fluconazole (Diflucan)
☐ Ganciclovir (DHPG, Cytovene)

ML2A1_39 - ML212_39

COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q 15.C(1)

D. (1) [Since your last visit in (MONTH)] 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 16  OMDAD_39

☐ Yes

(2) Please name the other HIV related therapies you have taken.

1. OMDA1_39

2. OMDA2_39

3. OMDA3_39

4. OMDA4_39

5. OMDA5_39

6. OMDA6_39

7. OMDA7_39

8. OMDA8_39

9. OMDA9_39
16. 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 [since your visit in (MONTH)].

<table>
<thead>
<tr>
<th>ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 15a)</th>
<th>How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)].</th>
<th>When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Steroids that you took by mouth or were injected</td>
<td>NO YES</td>
<td>STRAV_39</td>
</tr>
<tr>
<td>2) Thyroid hormone or medication</td>
<td></td>
<td>THYRV_39</td>
</tr>
<tr>
<td>3) Other hormones such as anabolic steroids</td>
<td></td>
<td>HORMV_39</td>
</tr>
<tr>
<td>4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug</td>
<td></td>
<td>ANTBV_39</td>
</tr>
<tr>
<td>5) Medication taken by mouth for fungal infection</td>
<td></td>
<td>FGMDV_39</td>
</tr>
<tr>
<td>6) Medication taken by mouth for worms or parasites</td>
<td></td>
<td>WRMDV_39</td>
</tr>
<tr>
<td>7) Tranquilizers or sleeping pills</td>
<td></td>
<td>TRNQV_39</td>
</tr>
<tr>
<td>IF YES, have you taken/used any in the last 7 days?</td>
<td>No, Yes</td>
<td>TRNQ7_39</td>
</tr>
<tr>
<td>8) Antidepressants or mood elevators</td>
<td></td>
<td>MOODV_39</td>
</tr>
<tr>
<td>9) Lithium</td>
<td></td>
<td>LITHV_39</td>
</tr>
<tr>
<td>10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, was this for:</td>
<td></td>
<td>ACYCV_39</td>
</tr>
<tr>
<td>chronic herpes?</td>
<td>No, Yes</td>
<td>CHACY_39</td>
</tr>
<tr>
<td>episodic herpes?</td>
<td>No, Yes</td>
<td>EPACY_39</td>
</tr>
<tr>
<td>11) Viagra</td>
<td></td>
<td>VIAGR_39</td>
</tr>
<tr>
<td>12) Cholesterol, triglycerides or lipid lowering medications</td>
<td></td>
<td>CHOL1_39</td>
</tr>
<tr>
<td>a. (SPECIFY in column b)</td>
<td></td>
<td>CHDG1_39</td>
</tr>
<tr>
<td>b. (SPECIFY in column b)</td>
<td></td>
<td>CHOL2_39</td>
</tr>
<tr>
<td>c. (SPECIFY in column b)</td>
<td></td>
<td>CHOL3_39</td>
</tr>
<tr>
<td>13) Medications used for diabetes</td>
<td></td>
<td>DIAB1_39</td>
</tr>
<tr>
<td>a. (SPECIFY in column b)</td>
<td></td>
<td>DIAT1_39</td>
</tr>
<tr>
<td>13) Medications used for diabetes (cont.)</td>
<td>14) Hepatitis medications</td>
<td>15) Other</td>
</tr>
<tr>
<td>------------------------------------------</td>
<td>--------------------------</td>
<td>----------</td>
</tr>
<tr>
<td>b. (SPECIFY in column b)</td>
<td>a. (SPECIFY in column b)</td>
<td>a. (SPECIFY in column b)</td>
</tr>
<tr>
<td>c. (SPECIFY in column b)</td>
<td>b. (SPECIFY in column b)</td>
<td>b. (SPECIFY in column b)</td>
</tr>
<tr>
<td>d. (SPECIFY in column b)</td>
<td>c. (SPECIFY in column b)</td>
<td>c. (SPECIFY in column b)</td>
</tr>
<tr>
<td>e. (SPECIFY in column b)</td>
<td>d. (SPECIFY in column b)</td>
<td>d. (SPECIFY in column b)</td>
</tr>
<tr>
<td>f. (SPECIFY in column b)</td>
<td>e. (SPECIFY in column b)</td>
<td>e. (SPECIFY in column b)</td>
</tr>
<tr>
<td>g. (SPECIFY in column b)</td>
<td>f. (SPECIFY in column b)</td>
<td>f. (SPECIFY in column b)</td>
</tr>
</tbody>
</table>

**How about (EACH)?** Have you (taken/used) any (since your visit in (MONTH))? When specified, what was the name of the (KIND OF DRUG) you look and what did you take this drug for?
17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?
   ○ No  [SKIP TO Q 18]  ○ Yes  [HIVAC_39]

B. Do you know the name of the trial?  [HVACC_39]
   ○ No  ○ Yes  [Specify]  [HVACN_39]

C. Where did you go for this trial?
   [Name of hospital or clinic]
   [Address]
   [City]  [State]
   [Date started trial]

---

I would now like to ask you about your medical coverage.

18.A. Since your last visit did you have [ASK EACH ITEM AND RECORD ANSWER] [ASK EACH ITEM AND RECORD ANSWER]
   1) Coverage by an HMO  [HMOC_39]
   2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)  [GPIC_39]
   3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)  [IPIC_39]
   4) Medicaid, Medi-Cal, or Medical Assistance  [MCAID_39]
   5) Medicare (for people over 65 or permanently disabled)  [MCARE_39]
   6) Long-term care benefits for Armed Forces or veterans’ Administration [VABEN_39]
   7) TRICARE or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans [CHAMP_39]
   8) ADAP (AIDS Drug Assistance Program)  [ADAP_39]
   9) Other  [OTHER_39]

18.B. Do you have insurance coverage that pays for any of your medications?  [INSDG_39]

IF NO TO Q 18.A (1)–(9) AND Q 18.B, THEN SKIP TO Q 22

19. A. Since your last visit, have you changed or lost your medical coverage?  [INSCH_39]
   ○ NO  ○ YES

B. If YES, was that change your choice?  [CHOIC_39]

C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION]
   1) Lost or quit job  [INCLJ_39]
   2) Changed job (employer or employment status)  [INCCJ_39]
   3) Employer changed or dropped coverage  [INCEM_39]
   4) Pre-existing medical condition limited choices  [INCMC_39]
   5) To be able to choose doctors or providers  [INCMD_39]
   6) More or better coverage of needed or desired services  [INCCV_39]
   7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed  [INCEL_39]
   8) Financial reasons (cost of premiums, co-payments or deductibles)  [INCFR_39]
   9) Eligible for Medicare  [INCM_39]

D. [IF “YES” TO MORE THAN ONE RESPONSE IN Q 19.C, ASK] Which one was the PRIMARY reason? [READ ALL CHOICES AND SELECT ONLY ONE]
   ○ Lost or quit job  [INCPR_39]
   ○ 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
19. E. Are you currently insured?
   - No
   - Yes

20. A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)
   1) Employer offers only one plan
   2) Only eligible for current coverage due to medical condition
   3) To be able to choose doctors or providers
   4) To have more or better coverage of needed or desired services
   5) Eligible for Medicaid, Medi-Cal, or Medical Assistance
   6) Financial reasons (cost of premiums, co-payments or deductibles)
   7) Eligible for Medicare

B. [IF "YES" TO MORE THAN ONE RESPONSE IN Q20.A, ASK] What was the PRIMARY reason for choosing your current medical coverage? [READ ALL CHOICES AND SELECT ONE]
   - Employer offers only one plan
   - Only eligible for current coverage due to medical condition
   - To be able to choose doctors or providers
   - To have more or better coverage of needed or desired services
   - Eligible for Medicaid, Medi-Cal, or Medical Assistance
   - Financial reasons (cost of premiums, co-payments or deductibles)
   - Eligible for Medicare

21. All things considered, how satisfied are you with your current health insurance plan? [SHOW CARD TO PARTICIPANT OR READ ALOUD]
   - Completely satisfied, couldn’t be better
   - Very satisfied
   - Somewhat satisfied
   - Neither satisfied nor dissatisfied
   - Somewhat dissatisfied
   - Very dissatisfied
   - Completely dissatisfied, couldn’t be worse

22. Did you have any type of dental insurance coverage at any time since your last visit in (MONTH)?
   - No
   - Yes

23. Where do you usually go for medical care, even if you haven’t received medical care since your last visit?
   - [READ ALL CHOICES AND SELECT ONLY ONE]
   - HMO
   - Doctor’s office or specialty clinic (non-HMO) including Urgent Care
   - Any other clinic
   - Emergency room
   - Other outpatient

24. Since your visit in (MONTH), 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.]

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Have you used (EACH) since your last visit?</th>
<th>How many times? (99 = 99 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) HMO</td>
<td>NO</td>
<td>203770–7/7</td>
</tr>
<tr>
<td>2) Doctor’s office or specialty clinic (non-HMO) including Urgent Care</td>
<td>NO</td>
<td>203770–7/7</td>
</tr>
<tr>
<td>3) Any other clinic</td>
<td>NO</td>
<td>203770–7/7</td>
</tr>
<tr>
<td>4) Emergency room</td>
<td>NO</td>
<td>203770–7/7</td>
</tr>
<tr>
<td>5) Other outpatient</td>
<td>NO</td>
<td>203770–7/7</td>
</tr>
</tbody>
</table>

Specify:
25. Since your last visit in (MONTH), have you used ANY of the following providers or services?

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Have you used (EACH) since your last visit in (MONTH)?</th>
<th>How many times? (99 = 99 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Dental health care provider (such as dentist or dental hygienist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/counselor)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**SERVICE**

**DENTV** 
**DHNUM**

**USEMH** 
**MHNUM**

**USEAO** 
**AONUM**

**USEHC** 
**HCNUM**

How many times? (99 = 99 or more)
32. Since your last visit, has your employment status changed for any reason related to HIV disease?

- No
- Yes

   IF YES: ASK: What were the reasons?
   
   - Became too sick to work
   - HIV status became known to employer
   - HIV status became known to coworkers
   - Early retirement
   - Changed job as a personal decision
   - To receive better health insurance benefits
   - To receive better disability benefits
   - Other

   Specify:

26. Please estimate the **TOTAL** out-of-pocket expenses that you or other personal sources (your lover, family or friends) paid for prescription medications since your last visit in (MONTH).

   - Round to nearest dollar, code "0" if less than $1

   Specify:

29. Was there a time since your last visit when you were refused dental care?

- No
- Yes

30. Are you experiencing major financial difficulty meeting your basic expenses?

   - No
   - Yes

   IF YES: Is the difficulty less, the same or greater than at your last visit in (MONTH)?

   - Less
   - Same
   - Greater

31. At present, which of the following categories describes your annual individual gross income before taxes?

   - 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
I am going to ask you a series of questions about specific behaviors, including cigarette smoking, alcohol use, sexual behavior, and recreational drug use.

33. Now I have some questions about cigarette smoking.
   A. Have you ever smoked cigarettes?
      - No [SKIP TO Q 34]
      - Yes [ESMOK_39]
   B. Do you smoke cigarettes now? (As of one month ago?)
      - No [SKIP TO Q 34]
      - Yes [SMOKN_39]
      - Occasionally (less than one cigarette per day) [SKIP TO Q 34]
   C. How many packs do you usually smoke per day?
      - Less than 1/2 pack [PACKS_39]
      - 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

34. The next questions are about alcoholic beverages—
that is, wine, beer or liquor you’ve drunk [since your visit in (MONTH)].
   A. Did you drink any alcoholic beverages [since your visit in (MONTH)]?
      - No [SKIP TO Q 34.D]
      - Yes [DRNK_39]
   B. How often do 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
   C. [Since your visit in (MONTH)] On days when you drank any alcoholic beverages, how many drinks did you USUALLY have altogether?
      - 1 or 2 drinks
      - 3 or 4 drinks
      - 5 or 6 drinks
      - 7 or more drinks
      - No
      - Yes
      - [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.]
      - [SKIP TO Q 42]

35. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)]?
   - No [SKIP TO Q 42]
   - Yes [SEXAV_39]

36. Have you had any sexual activity with a woman since your last visit?
   - No [SKIP TO Q 39]
   - Yes [SEXVF_39]

37. Now lets talk about how many different women you have had sexual activity with since your last visit.
   A. How many different women (if any) have you had sexual intercourse with since your last visit? Here we define sexual intercourse as inserting your penis into your partner’s mouth, vagina, or anus/butt, with or without ejaculation.
      - NSEXF_39
   B. With how many other women have you had sexual activity that did not include intercourse since your last visit?
      - NSXAF_39
The next questions are about different kinds of sexual activity men have with women. IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 38.10

38. IF ONLY ONE PARTNER: USE COLUMN a.
   IF MULTIPLE PARTNERS: USE COLUMN b.

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).</td>
<td>OINF1_39</td>
<td></td>
</tr>
<tr>
<td>2) With how many of those women did you use a condom every time for oral sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time you had oral sex even if it broke, tore, or slipped?</td>
<td>COIF1_39</td>
<td>NCOIF_39</td>
</tr>
<tr>
<td>3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</td>
<td>OEJF1_39</td>
<td>NOEJF_39</td>
</tr>
<tr>
<td>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</td>
<td>VINF1_39</td>
<td></td>
</tr>
<tr>
<td>5) With how many of those women did you use a condom every time for vaginal sex, even if it broke, tore, or slipped? IF ONE PARTNER: Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td>CVIF1_39</td>
<td>NCVIF_39</td>
</tr>
<tr>
<td>6) With how many women did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</td>
<td>VEJF1_39</td>
<td>NVEJF_39</td>
</tr>
</tbody>
</table>

---

SERIAL #
38. Continued

**KIND OF ACTIVITY**

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a woman since your last visit?</th>
<th>How many women did you do that with (since your last visit)? (Give me the actual number) (IF NEEDED: What's your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>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)?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (“rimming”).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

39. Have you had any sort of sexual activity with a man since your last visit?

- **No** → **Yes** → **SKIP TO Q 42**

**SEXVM_39**

40. Now let's talk about how many different men you have had sexual activity with since your last visit.

A. How many different men (if any) have you had sexual intercourse with since your last visit? 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.

**NSEXM_39**

B. With how many other men have you had sexual activity that did not include intercourse since your last visit?

**NNSXM_39**
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 41.13.

41. If only one partner: Use column a.
   If multiple partners: Use column b.

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>NO</th>
<th>YES</th>
<th>How many men did you do that with (since your last visit)? (Give me the actual number) (If needed: What's your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) You put your penis in his mouth. If none, skip to item (4).</td>
<td>NO</td>
<td>YES</td>
<td>ORIN1_39</td>
</tr>
<tr>
<td>2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
<td>COIN1_39</td>
</tr>
<tr>
<td>3) Thinking of the times you put your penis in his mouth, did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
<td>NCOIM_39</td>
</tr>
<tr>
<td>4) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
<td>OEJM1_39</td>
</tr>
<tr>
<td>5) Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
<td>NOEJM_39</td>
</tr>
<tr>
<td>4) You put your penis in his anus/butt. If none, skip to item (7).</td>
<td>NO</td>
<td>YES</td>
<td>ANIN1_39</td>
</tr>
<tr>
<td>5) Thinking of the times you put your penis in their anus/butt, with how many men did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
<td>CAIN1_39</td>
</tr>
<tr>
<td>6) Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
<td>NCAIM_39</td>
</tr>
<tr>
<td>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)?</td>
<td>NO</td>
<td>YES</td>
<td>AEJM1_39</td>
</tr>
<tr>
<td>6) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
<td>NAEJM_39</td>
</tr>
</tbody>
</table>

How many men did you do that with (since your last visit)? (Give me the actual number) (If needed: What's your best estimate?)

Did you do this/engage in this activity with a man since your last visit?
### Kind of Activity

<table>
<thead>
<tr>
<th>Activity</th>
<th>Question</th>
<th>How Many Men Did You Do That With (Since Your Last Visit)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>7</td>
<td>He put his penis in your mouth.</td>
<td>No: ORRC1_39, Yes: NORCMI_39</td>
</tr>
<tr>
<td>8</td>
<td>Thinking of the times when a man put his penis in your mouth, with how many men was a condom used every time, even if it broke, tore, or slipped?</td>
<td>No: CORR1_39, Yes: NCORCI_39</td>
</tr>
<tr>
<td>9</td>
<td>With how many men did ejaculate/cum go into your mouth when they did not use a condom (or when a condom failed)?</td>
<td>No: OREM1_39, Yes: NOREM_39</td>
</tr>
<tr>
<td>10</td>
<td>He put his penis in your anus/butt.</td>
<td>No: ANRC1_39, Yes: NARCI_39</td>
</tr>
<tr>
<td>11</td>
<td>Thinking of the times when a man put his penis in your anus/butt, with how many men was a condom used every time, even if it broke, tore, or slipped?</td>
<td>No: CANR1_39, Yes: NCARN_39</td>
</tr>
<tr>
<td>12</td>
<td>With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)?</td>
<td>No: AREM1_39, Yes: NAREM_39</td>
</tr>
<tr>
<td>13</td>
<td>You used your tongue to touch or lick his anus/butt (&quot;rimming&quot;).</td>
<td>No: RIM1_39, Yes: NIRM1_39</td>
</tr>
</tbody>
</table>
42. 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 [since your visit in (MONTH)]?

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Daily</th>
<th>Weekly</th>
<th>Monthly</th>
<th>Less Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pot, Marijuana or Hash</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>&quot;Poppers&quot; like nitrite inhalants (amyl, butyl or isopropyl nitrites)</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crack or cocaine that you smoke</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other forms of cocaine</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speed, Meth or Ice</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speedball (heroin and cocaine together)</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy, XTC, X or MDMA</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other kinds of street/club drugs</td>
<td>NO</td>
<td>YES</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify:

```
Specify:
 Specify:
 Specify:
 Specify:
 Specify:
 Specify:
```
43. A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?
   ○ No  →  SKIP TO Q 49  RCDRG_39
   ○ Yes

   B. Were any of these times that you injected recreational drugs in a shooting gallery?
   ○ No  →  RCDSG_39
   ○ Yes

   C. Do you currently inject drugs?
   ○ No  →  RCDNO_39
   ○ Yes

   D. Thinking about the period when you injected the most, how many times did you inject [DRUG] per month?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>TNSB_39</th>
<th>TINCO_39</th>
<th>TINHO_39</th>
<th>TINSO_39</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speedball (cocaine and</td>
<td>0, 10,</td>
<td>0, 1, 2,</td>
<td>0, 1, 2,</td>
<td>0, 1, 2,</td>
</tr>
<tr>
<td>heroin together)</td>
<td>20, 30,</td>
<td>3, 4, 5,</td>
<td>3, 4, 5,</td>
<td>3, 4, 5,</td>
</tr>
<tr>
<td></td>
<td>40, 50,</td>
<td>6, 7, 8,</td>
<td>6, 7, 8,</td>
<td>6, 7, 8,</td>
</tr>
<tr>
<td></td>
<td>60, 70,</td>
<td>9, 10,</td>
<td>9, 10,</td>
<td>9, 10,</td>
</tr>
<tr>
<td></td>
<td>80, 90</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

44. [Since your last visit in (MONTH)] have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?
   ○ No  →  SHRNW_39  SKIP TO Q 46
   ○ Yes

45. A. [Since your last visit in (MONTH)] how many times have you used needles or works that were first used by someone else and then passed to you?
   ○ No  →  TSHNW_39
   ○ Yes

   B. With how many different people?
   ○ No  →  SHWNP_39
   ○ Yes

46. A. [Since your last visit in (MONTH)] have you shared water to rinse your needles with anyone?
   ○ No  →  SH2OR_39  SKIP TO Q 47
   ○ Yes

   B. How many times?
   ○ No  →  TSH2O_39

   C. With how many different people?
   ○ No  →  DPH2O_39

47. [Since your last visit in (MONTH)] how often did you clean your works with bleach?
   ○ Never  →  FBLEA_39
   ○ Less than half the time
   ○ About half the time
   ○ Most of the time
   ○ Always

48. A. [Since your last visit in (MONTH)] have you participated in a needle exchange program?
   ○ No  →  PNEP_39  SKIP TO Q 49
   ○ Yes

   B. Of the times you obtained needles, how often did you get them from a needle exchange?
   ○ No  →  HONEP_39
   ○ Yes

   C. Do you have another source of clean needles?
   ○ No  →  OSCLN_39
   ○ Yes

49. [Since your last visit in (MONTH)] 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  →  DRGTP_39
   ○ Yes
50. A. Is there anything more that I haven't asked that you think we should know?
   - No, nothing more
   - Yes
   
51. ACASI interview?
   - No
   - Yes

52. Telephone interview?
   - No
   - Yes

53. Home visit?
   - No
   - Yes

54. PWA interview?
   - No
   - Yes
   - Don't know

55. Returning censored participant?
   - No
   - Yes

56. Date interview completed
   
57. Interviewer’s signature
   
58. Are you of Hispanic (Spanish) or Latino origin?
   - No
   - Yes

59. What is your race? Do you consider yourself . . .? (Read each and mark all that apply.)
   - White
   - Black
   - Alaskan Native
   - Asian

   - Native Hawaiian (Pacific Islander)
   - Native American (North, South, Central) Indian
   - Other

THANK PARTICIPANT AND SKIP TO Q 51.

RECORD FULLY IN R’s OWN WORDS.

B. Tell me about it.

INTERVIEWER’S NUMBER

INTERVIEW’S NUMBER

TIME ENDED

SERIAL #