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

### A. Kaposi's sarcoma or KS
- **NO**
- **YES**

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**In what month and year (since your last visit), was it (first) diagnosed?**

1. **J F M A M J J A S O N D**

2. **04 05 06 07 08 09 10 11 12**

### B. Pneumocystis carinii pneumonia (PCP)
- **NO**
- **YES**

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**In what month and year (since your last visit), was it (first) diagnosed?**

1. **J F M A M J J A S O N D**

2. **04 05 06 07 08 09 10 11 12**

### C. Other pneumonia, specify
- Pneumococcal
- Other bacterial
- Viral
- Other

Specify:

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

If more than 1 time, in what month and year was the most recent episode?

Specify:

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### D. Toxoplasmosis or Toxo infection
- **NO**
- **YES**

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it?
- **NO**
- **YES**

**CODE ALL THAT APPLY (DO NOT CODE "YES" IF ONLY CMV ANTIBODIES.)**

- Eyes
- Lung
- Colon
- Other (not blood)

Specify:

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

### F. Mycobacterial infection (MAC, MAI or atypical TB)
- **NO**
- **YES**

<table>
<thead>
<tr>
<th>ID NUMBER</th>
<th>VISIT NO.</th>
<th>TIME BEGAN</th>
<th>DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3 0</td>
<td>1 2 3</td>
</tr>
</tbody>
</table>

**PLEASE DO NOT WRITE IN THIS AREA**

[Image of a form with markings instructions and table headings]
1. Continued

<table>
<thead>
<tr>
<th>IF &quot;NO&quot; TO a, GO TO NEXT ROW</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Lymphoma, specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Primary brain lymphoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Non-Hodgkin’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>○ Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Specified</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Meningitis related to HIV or cryptococcal meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Candida or thrush, a yeast infection of the esophagus, not just your mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Cryptosporidiosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Wasting Syndrome or severe weight loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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? Record the name and address of the physician who diagnosed the condition(s) in above box.

○ No → SKIP TO Q 3

○ Yes

IF "YES": What was the diagnosis?

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

Name of hospital/clinic or doctor

Address

City State
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)?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

If "NO," GO TO Q 4

**IF YES:** Where in the body was the cancer and what kind of cancer did they say it was?

<table>
<thead>
<tr>
<th>Type</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

B. **IF YES:** When was your last test?

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Was it positive?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

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

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

B. Was the TB in your lungs?

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
</table>

C. Was the TB in any other part of your body (other than your lungs)?
IF MORE THAN 2 HOSPITALIZATIONS/OUTPATIENT PROCEDURES [SINCE VISIT IN (MONTH)], MARK HERE AND USE CONTINUATION SHEET.

3/8" spine perf

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

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

☐ No _______ SKIP TO Q 7
☐ Yes

How many separate times were you a patient in a hospital [since your visit in (MONTH)]?

☐ 5 6 7 8 9 10 11 12 13 14 15 16
☐ 1 2 3 4 5 6 7 8 9 0

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

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

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

   MO J F M A M J J A G O N D
   DAY 1 2 3 4 5 6 7 8 9 10 11 12
   YEAR 19 89 90 91 92 93 94 95 96 97 98 99

   IF OUTPATIENT: FILL IN ZERO.

b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

   NIGHTS 0 1 2 3 4 5 6 7 8 9

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

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

       RECORD FULLY IN R's OWN WORDS.

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

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

   ☐ No _______ SKIP TO Q 7
   ☐ Yes

   IF MORE THAN 2 HOSPITALIZATIONS/OUTPATIENT PROCEDURES [SINCE VISIT IN (MONTH)], MARK HERE AND USE CONTINUATION SHEET.

   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

   IF YES: which month and year was the most recent time?

   MO J F M A M J J A G O N D
   DAY 1 2 3 4 5 6 7 8 9 10 11 12
   YEAR 19 89 90 91 92 93 94 95 96 97 98 99

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

       RECORD FULLY IN R's OWN WORDS.

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

IF ONLY ONE HOSPITALIZATION (SEE RESPONSE TO 6.A.), SKIP TO QUESTION 7

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

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

   MO J F M A M J J A G O N D
   DAY 1 2 3 4 5 6 7 8 9 10 11 12
   YEAR 19 89 90 91 92 93 94 95 96 97 98 99

   IF OUTPATIENT: FILL IN ZERO.

b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

   NIGHTS 0 1 2 3 4 5 6 7 8 9

   IF AIDS RELATED, CODE IN QUESTIONS 1–3 AS APPROPRIATE
8.B. I would like you to think about other conditions and procedures or treatments that you may have had in the past. Has a doctor or other medical practitioner ever told you that you had...

GET MEDICAL RELEASE IF FIRST DIAGNOSIS WAS MADE IN PAST 6 MONTHS.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Question</th>
<th>Year Options</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>high cholesterol, high triglycerides, high lipids or too much fat in your blood?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>high blood sugar or diabetes?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>high blood pressure or hypertension?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>a stroke or CVA?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>chest pain or angina related to heart disease?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>a heart attack or myocardial infarction (MI)?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>congestive heart failure or CHF?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>mini-strokes or transient ischemic attacks (TIA)?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>too fast, too slow, or irregular heart beat?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>any blood vessels (arteries) that were blocked or closed?</td>
<td>IF YES: In what year was it first diagnosed?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>an operation to open blocked blood vessels in your heart or other areas?</td>
<td>IF YES: In what year did you have the operation?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>a blood clot in your legs?</td>
<td>IF YES: In what year did this first occur?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td>a blood clot in your lungs?</td>
<td>IF YES: In what year did this first occur?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
</tbody>
</table>

C. Have any members of your immediate family ever suffered from (each)?

<table>
<thead>
<tr>
<th>Member</th>
<th>Condition</th>
<th>Year Options</th>
<th>Response Options</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>high cholesterol, high triglycerides, high lipids or too much fat in your blood?</td>
<td>Before 1989</td>
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<td>too fast, too slow, or irregular heart beat?</td>
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<td>any blood vessels (arteries) that were blocked or closed?</td>
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<td>an operation to open blocked blood vessels in your heart or other areas?</td>
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<td></td>
<td>a blood clot in your legs?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
<tr>
<td></td>
<td>a blood clot in your lungs?</td>
<td>Before 1989</td>
<td>Yes No Don't Know</td>
</tr>
</tbody>
</table>
8.D. Have any members of your immediate family suffered from cancer?

IF YES: Was it:
- a. Skin cancer
- b. Colon cancer
- c. Prostate cancer
- d. Cervical cancer (female family members)
- e. Anal cancer
- f. Other cancer

9.A.(1) Have you ever undergone an anal biopsy?
(By a biopsy, we mean removal of any tissue or gland to study under the microscope.)
- No
- Yes

(2) How many times have you had an anal biopsy with abnormal results?
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9
- [ ] 10

If zero times, go to Q 9.B. If one or more times GET MEDICAL RELEASE.

(3) In what month and year were you [first] diagnosed with abnormal results?
- [ ] January
- [ ] February
- [ ] March
- [ ] April
- [ ] May
- [ ] June
- [ ] July
- [ ] August
- [ ] September
- [ ] October
- [ ] November
- [ ] December

If more than one abnormal biopsy, ask Q 9.A (4). If NOT, go to Q 9.B.

(4) In what month and year were you last diagnosed with abnormal results?
- [ ] January
- [ ] February
- [ ] March
- [ ] April
- [ ] May
- [ ] June
- [ ] July
- [ ] August
- [ ] September
- [ ] October
- [ ] November
- [ ] December

9.B.(1) Have you ever undergone an anal pap smear?
- No
- Yes

(2) In what month and year did you have the pap smear performed?
- [ ] January
- [ ] February
- [ ] March
- [ ] April
- [ ] May
- [ ] June
- [ ] July
- [ ] August
- [ ] September
- [ ] October
- [ ] November
- [ ] December

(3) Were the results abnormal?
- No
- Yes

9.C.(1) [Since your visit in (MONTH)] Have you had any other biopsies?
- No
- Yes

(2) How many times have you had a biopsy [since your last visit in (MONTH)]?
- [ ] 1
- [ ] 2
- [ ] 3
- [ ] 4
- [ ] 5
- [ ] 6
- [ ] 7
- [ ] 8
- [ ] 9

(3) For each biopsy, please tell me:

<table>
<thead>
<tr>
<th>Where in your body?</th>
<th>What did they say the diagnosis or result of the biopsy was?</th>
<th>Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Specify:</td>
<td>Specify:</td>
<td>Name of doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of hospital/center/clinic:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City: State: DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of hospital/center/clinic:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City: State: DATE</td>
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<tr>
<td></td>
<td></td>
<td>Name of doctor</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Name of hospital/center/clinic:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City: State: DATE</td>
</tr>
</tbody>
</table>
10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

A. Shingles (or herpes zoster) ☐ ☐

B. Thrush (yeast in your mouth) ☐ ☐

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. Anemia, low RBC, low hemoglobin ☐ ☐

K. Chest pain related to heart disease or angina ☐ ☐

L. Heart attack or myocardial infarction (MI) ☐ ☐

M. Congestive heart failure or CHF ☐ ☐

N. Stroke or CVA ☐ ☐

O. Seizure ☐ ☐

P. Osteoporosis (bone thinning) ☐ ☐

Q. Arthritis
   IF YES: Was it:
   Rheumatoid ☐ ☐
   Osteoarthritis or degenerative ☐ ☐
   Other ☐ ☐
   Specify:
   Don’t know ☐ ☐

R. Avascular necrosis, osteonecrosis, or had a hip replacement ☐ ☐

S. Kidney disease/Renal failure ☐ ☐

T. 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 ☐ ☐
   (Read and answer each.)
   Specify:
   Other ☐ ☐
   Don’t know ☐ ☐

U. Liver disease
   GET MEDICAL RELEASE ☐ ☐
   IF YES: Was it:
   Cirrhosis ☐ ☐
   Fibrosis ☐ ☐
   Inflammation ☐ ☐
   Elevated liver function test/enzyme ☐ ☐
   Other ☐ ☐
   Specify:
   Don’t know ☐ ☐

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

Name of hospital/clinic or doctor
Address
City State

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

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

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

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?
Specify:

---

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 and Sinuses
   IF YES: Was there a diagnosis?
   What was the diagnosis?

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

d) Lungs and Bronchial Tubes
   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?

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

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

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

j) Psychological
   IF YES: Was there a diagnosis?
   What was the diagnosis?
Z. Continued

k) Hormones or Endocrine system
   **IF YES:** Was there a diagnosis?
   What was the diagnosis?

l) Blood and Fluids
   **IF YES:** Was there a diagnosis?
   What was the diagnosis?

m) Allergy and Immune system other than HIV infection
   **IF YES:** Was there a diagnosis?
   What was the diagnosis?

n) Other
   **IF YES:** Was there a diagnosis?
   What was the diagnosis?

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

   **IF “NO” TO ALL FOUR, SKIP TO Q 12**

<table>
<thead>
<tr>
<th>DISEASE OR CONDITION</th>
<th>HAD DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Syphilis</td>
<td>NO</td>
</tr>
<tr>
<td>B) Any form of gonorrhea</td>
<td>NO</td>
</tr>
<tr>
<td>C) Urethral gonorrhea (clap or drip of the urinary passage)</td>
<td>NO</td>
</tr>
<tr>
<td>D) Oral gonorrhea (of the mouth or throat)</td>
<td>NO</td>
</tr>
<tr>
<td>E) Rectal gonorrhea (of the rectum)</td>
<td>NO</td>
</tr>
<tr>
<td>F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that’s not caused by gonorrhea)</td>
<td>NO</td>
</tr>
<tr>
<td>G) Genital warts (condylomata acuminata)</td>
<td>NO</td>
</tr>
<tr>
<td>H) Anal warts (condylomata acuminata)</td>
<td>NO</td>
</tr>
<tr>
<td>I) Chlamydia</td>
<td>NO</td>
</tr>
<tr>
<td>J) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis</td>
<td>NO</td>
</tr>
</tbody>
</table>

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)?

<table>
<thead>
<tr>
<th>DISEASE OR CONDITION</th>
<th>HAD DISEASE</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Syphilis</td>
<td>NO</td>
</tr>
<tr>
<td>B) Any form of gonorrhea</td>
<td>NO</td>
</tr>
<tr>
<td>C) Urethral gonorrhea (clap or drip of the urinary passage)</td>
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</tr>
<tr>
<td>D) Oral gonorrhea (of the mouth or throat)</td>
<td>NO</td>
</tr>
<tr>
<td>E) Rectal gonorrhea (of the rectum)</td>
<td>NO</td>
</tr>
<tr>
<td>F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that’s not caused by gonorrhea)</td>
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</tr>
<tr>
<td>G) Genital warts (condylomata acuminata)</td>
<td>NO</td>
</tr>
<tr>
<td>H) Anal warts (condylomata acuminata)</td>
<td>NO</td>
</tr>
<tr>
<td>I) Chlamydia</td>
<td>NO</td>
</tr>
<tr>
<td>J) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis</td>
<td>NO</td>
</tr>
</tbody>
</table>
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 YES, GO TO COLUMN E</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>1) Persistent dizziness for at least 3 consecutive days</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>2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days</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>3) Persistent or recurring fever higher than 100° for at least 3 consecutive days</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>4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days</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>5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days</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>6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days</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>7) Diarrhea for at least 3 consecutive days</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>8) Drenching sweats at night on at least 3 occasions</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>9) Nausea, vomiting</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>10) Abdominal pain, bloating, cramps</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>11) Ascites (fluid buildup in the stomach or abdomen)</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>12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)</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>13) An unusual bruise or bump or skin discoloration that lasted at least two weeks</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>14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)</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>15) Blood in urine</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>
</tbody>
</table>
### 13.A. Continued

### Problem or Symptom

For each "YES" in a, ASK b, c, d, and e.

<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 YES, GO TO COLUMN E</th>
<th>WHEN BEGAN (Month and Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>16) 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>17) Muscle pain or weakness</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18) Joint pain</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19) Painful urination</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20) Kidney stones</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>21) Vivid nightmares or dreams</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>22) Insomnia or problems sleeping</td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

### 13.B. [Since your last visit in (MONTH)]

**Have you experienced:**

**If NO, go to next question. If YES, indicate severity.**

#### Severity

(0= None, 1= Mild, 10= Severe)

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
<td>Left</td>
</tr>
</tbody>
</table>

1. Pain, aching, or burning in your feet or legs?

2. Pins and needles in your feet or legs?

3. Numbness (lack of feeling) in your feet or legs?
3-TC (Epivir, Lamivudine)
Abacavir (Ziagen)
Amprenavir (Agenerase)
AZT (Retrovir, Zidovudine)
Atazanavir (Reyataz BMS-232632)
Combivir (AZT & 3-TC)
d4T (Zerit, Stavudine)
Didanosine (Dideoxyinosine, DDI, Videx)
Delavirdine (Rescriptor)
Efavirenz (Sustiva)
Emtriva (Emtricitabine, Coviracil, FTC)
Epzicom (Abacavir + Lamivudine)
Fuzeon (Pentafuside, Enfuvirtide, T-20)
Indinavir (Crixivan)
Lexiva (Fosamprenavir)
Lopinavir/r (Kaletra)
Nelfinavir (Viracept)
Nevirapine (Viramune)
Ritonavir (Norvir)
Saquinavir (Invirase, Fortovase)
Tenofovir (Viread)
Tipranavir
Trizivir (Abacavir + Zidovudine + Lamivudine)
Truvada (Tenofovir, Emtricitabine)

Other anti-viral from Drug List 1

FILL IN THE BUBBLE NEXT TO THE DRUG(S) AND THEN COMPLETE FORM 1 FOR EACH DRUG.

15.B. (3) Please name those drugs that you have taken or show me which ones.

No
Yes

IF YES: How many times did this occur?

0 1 02 03 04 05 06 07 08 09 0

0 1 02 03 04 05 06 07 08 09 0

0 1 02 03 04 05 06 07 08 09 0

0 1 02 03 04 05 06 07 08 09 0

STOP 

GO TO Q 16
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 [SKIP TO Q 15.D]
- Yes

(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. COMPLETE DRUG FORM 2 FOR EACH DRUG.**

- 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, Procril)
- Flagyl (metronidazole)
- Fluconazole (Diflucan)
- Ganciclovir (DHPG, Cytovene)
- Hydroxyurea (Hydra)
- Interleukin-2 (IL-2)
- Itraconazole (Sporonox)
- Ketoconazole (Nizoral)
- Megace
- Mycelex (clotrimazole)
- NAC (N-acetyl-cysteine)
- Nandralone (Deca-Durabolin)
- Nystatin (Mycostatin)
- Oxandrin (Oxandrolone)
- Pentamidine (aerosolized)
- Rifabutin (Ansamycin, Mycobutin)
- Serostim
- Testosterone (Delatestryl, Virilon, Testoderm, Androderm, Androgel)
- Vaccine trial (generic)
- Other from Drug List 2 (Report Acyclovir in Q 16.)

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 15.D]
- Yes

(2) Please name the other HIV related therapies you have taken.
16. Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include prescribed medications, over the counter medications, and other medications you took on your own [since your visit in (MONTH)].

<table>
<thead>
<tr>
<th>ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 17a)</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>
<th>Have you taken/used any in the past 3 days (FOR ASPIRIN: in the last week)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF “NO” TO a GO TO NEXT ITEM</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Steroids that you took by mouth or were injected</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>2) Thyroid hormone or medication</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>3) Other hormones such as anabolic steroids</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>5) Medication taken by mouth for fungal infection</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>6) Medication taken by mouth for worms or parasites</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>7) Tranquilizers or sleeping pills</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>8) Antidepressants or mood elevators</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>9) Lithium</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex)</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF YES, was this for:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>chronic herpes? ☐ No ☐ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>episodic herpes? ☐ No ☐ Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) Viagra or other drugs for erectile dysfunction</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>12) Aspirin taken three days or more on a weekly basis</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>13) Cholesterol, triglycerides, lipid or any blood fat lowering medications</td>
<td>NO YES</td>
<td>Name:</td>
<td>NO YES</td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14) Hypertension medications</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**15) Medications used for diabetes**

<table>
<thead>
<tr>
<th>a.</th>
<th>b.</th>
<th>c.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**16) Hepatitis medications**

<table>
<thead>
<tr>
<th>a.</th>
<th>b.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
</tr>
</tbody>
</table>

**17) Other**

<table>
<thead>
<tr>
<th>a.</th>
<th>b.</th>
<th>c.</th>
<th>d.</th>
<th>e.</th>
<th>f.</th>
<th>g.</th>
<th>h.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Used for:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?

- No [☐] → SKIP TO Q 18
- Yes [☐] →

B. Do you know the name of the trial?

- No [☐] →
- Yes [☐] → Specify:

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, have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

- No [☐] → SKIP TO Q 18.A9
- Yes - did you have

1) Coverage by an HMO [☐]
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) [☐]
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) [☐]
4) Medicaid, Medi-Cal, or Medical Assistance [☐]
5) Medicare (for people over 65 or permanently disabled) [☐]
6) Health care benefits for The Armed Forces or Veteran’s Administration [☐]
7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans [☐]
8) Other [☐] Specify:
9) ADAP (AIDS Drug Assistance Program) [☐]

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

- No [☐] →
- Yes [☐] →

19.A. Since your last visit, have you changed or lost your medical coverage?

- No [☐] → SKIP TO Q 19.C
- Yes - did you have

B. If YES, was that change your choice?

- No [☐] →
- Yes [☐] →

C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION]

1) Lost or quit job [☐]
2) Changed job (employer or employment status) [☐]
3) Employer changed or dropped coverage [☐]
4) Pre-existing medical condition limited choices [☐]
5) To be able to choose doctors or providers [☐]
6) More or better coverage of needed or desired services [☐]
7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed [☐]
8) Financial reasons (cost of premiums, co-payments or deductibles) [☐]
9) Eligible for Medicare [☐]
10) Other [☐] Specify:

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 [☐]
- 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 [☐]

E. Are you currently insured?

- No [☐] → SKIP TO Q 22
- Yes [☐] → GO TO Q 20A
20. A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)  

<table>
<thead>
<tr>
<th>Reason</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Employer offers only one plan</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Only eligible for current coverage due to medical condition</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) To be able to choose doctors or providers</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) To have more or better coverage of needed or desired services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5) Eligible for Medicaid, Medi-Cal, or Medical Assistance</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6) Financial reasons (cost of premiums, co-payments or deductibles)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7) Eligible for Medicare</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

21. All things considered, how satisfied are you with your current health insurance plan?  

<table>
<thead>
<tr>
<th>Satisfied Level</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Completely satisfied, couldn’t be better</td>
<td></td>
</tr>
<tr>
<td>2) Very satisfied</td>
<td></td>
</tr>
<tr>
<td>3) Satisfied</td>
<td></td>
</tr>
<tr>
<td>4) Neither satisfied nor dissatisfied</td>
<td></td>
</tr>
<tr>
<td>5) Somewhat dissatisfied</td>
<td></td>
</tr>
<tr>
<td>6) Very dissatisfied</td>
<td></td>
</tr>
<tr>
<td>7) Completely dissatisfied, couldn’t be worse</td>
<td></td>
</tr>
</tbody>
</table>

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?  

- No regular source of medical care
- Don’t know

B. [IF “YES” TO MORE THAN ONE RESPONSE IN Q 20.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

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.)  

<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, go to next row</td>
<td></td>
</tr>
<tr>
<td>2) Doctor’s office or specialty clinic (non-HMO) including Urgent Care</td>
<td>No, go to next row</td>
<td></td>
</tr>
<tr>
<td>3) Any other clinic</td>
<td>No, go to next row</td>
<td></td>
</tr>
<tr>
<td>4) Emergency room</td>
<td>No, go to next row</td>
<td></td>
</tr>
<tr>
<td>5) Other outpatient service (Specify below)</td>
<td>No, go to next row</td>
<td></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>☐ NO [GO TO NEXT ROW]</td>
<td>0  1  2  3  4  5  6  7  8  9</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td></td>
</tr>
<tr>
<td>2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/counselor)</td>
<td>☐ NO [GO TO NEXT ROW]</td>
<td>0  1  2  3  4  5  6  7  8  9</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td></td>
</tr>
<tr>
<td>3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)</td>
<td>☐ NO [GO TO NEXT ROW]</td>
<td>0  1  2  3  4  5  6  7  8  9</td>
</tr>
<tr>
<td></td>
<td>☐ YES</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>☐ NO [GO TO 0.25]</td>
<td>0  1  2  3  4  5  6  7  8  9</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td></td>
</tr>
</tbody>
</table>
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]

$ 0 | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9

OR
Don’t know
Refused

27A. Was there a time since your last visit in (MONTH) when you did not seek medical care, or dental care, or did not obtain prescription medications that you thought you needed?

☐ No  SKIP TO Q 28
☐ Yes

B. IF YES: Was there a time that you did not seek [obtain] (READ EACH) you thought you needed?

1) Medical care

☐ No  SKIP TO (2)
☐ Yes  Why did you not seek medical care?

[READ EACH AND MARK ALL THAT APPLY]

☐ Financial reasons
☐ Other non-financial reasons

Specify:

2) Dental care

☐ No  SKIP TO (3)
☐ Yes  Why did you not seek dental care?

[READ EACH AND MARK ALL THAT APPLY]

☐ Financial reasons
☐ Other non-financial reasons

Specify:

3) Prescription Medications

☐ No  SKIP TO Q 28
☐ Yes  Why did you not obtain prescription medications?

[READ EACH AND MARK ALL THAT APPLY]

☐ Financial reasons
☐ Other non-financial reasons

Specify:

28. Was there a time since your last visit when you were refused care from a doctor or other medical provider?

☐ No
☐ Yes

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

☐ No
☐ Yes

30A. Is there anything more that I haven’t asked that you think we should know?

☐ No, nothing more
☐ Yes

B. Tell me about it.
RECORD FULLY IN R’s OWN WORDS.


31. ACASI interview?

☐ No
☐ Yes

32. Telephone interview?

☐ No
☐ Yes

33. Home visit?

☐ No
☐ Yes
34. PWA interview?
   - No
   - Yes
   - Don’t know

35. Date interview completed

36. Interviewer’s signature

37. Are you of Hispanic (Spanish) or Latino origin?
   - No
   - Yes

38. 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

39. At present, which of the following categories describes your annual individual gross income before taxes? [SHOW CARD TO PARTICIPANT OR READ ALOUD.]
   - 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

40. Are you experiencing major financial difficulty meeting your basic expenses?
   - No [SKIP TO Q 41]
   - Yes

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

41. Since your last visit, has your employment status changed for any reason related to HIV disease?
   - No [SKIP TO Q 42]
   - Yes

   IF YES: ASK: What were the reasons?
   (READ EACH ITEM)
   - 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
I am going to ask you a series of questions about specific behaviors, including cigarette smoking, alcohol use, sexual behavior, and recreational drug use.

42. Now I have some questions about cigarette smoking.
   A. Have you ever smoked cigarettes?
      No  Yes  SKIP TO Q 43
   B. Do you smoke cigarettes now? (As of one month ago?)
      No  Yes  SKIP TO Q 43
      Occasionally (less than one cigarette per day)
   C. How many packs do you usually smoke per day?
      Less than 1/2 pack
      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

43. The next set of questions are about alcoholic beverages. They may seem similar, but they are asked in a slightly different way.

   Please answer each of the following questions for the past 6 months.

   A. How often have you had drinks containing alcohol?
      Never  Less than monthly  Monthly  Daily or almost daily
      STOP – SKIP TO Q 43K
   B. During the past 6 months, how many drinks containing alcohol have you had on a typical day when you are drinking? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.)
      1 or 2  3 or 4  5 or 6  7 to 9  10 or more  None
   C. During the past 6 months, how often have you had six or more drinks on one occasion? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.)
      Never  Less than monthly  Monthly  Daily or almost daily
   D. How often during the past 6 months have you found that you were not able to stop drinking once you started?
      Never  Less than monthly  Monthly  Daily or almost daily
   E. How often during the past 6 months have you failed to do what was normally expected from you because of drinking?
      Never  Less than monthly  Monthly  Daily or almost daily

F. How often during the past 6 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   Never  Less than monthly  Monthly  Daily or almost daily

G. How often during the past 6 months have you had a feeling of guilt or remorse after drinking?
   Never  Less than monthly  Monthly  Daily or almost daily

H. How often during the past 6 months have you been unable to remember what happened the night before because you had been drinking?
   Never  Less than monthly  Monthly  Daily or almost daily

I. Have you or someone else been injured as a result of your drinking?
   No  Yes, but not in the past 6 months  Yes, during the past 6 months

J. Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?
   No  Yes, but not in the past 6 months  Yes, during the past 6 months

K. Have you ever been in an alcohol treatment program, including inpatient and/or outpatient detox, alcoholics anonymous, and/or any other program?
   Yes  No

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.

44. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)]?
   No  Yes  SKIP TO Q 51

45. Have you had any sexual activity with a woman since your last visit?
   No  Yes  SKIP TO Q 48

GO TO QUESTION 46 ON NEXT PAGE.
46. Now let's 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.

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

The next questions are about different kinds of sexual activity men have with women.

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

<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>1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).</td>
<td></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></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</td>
<td></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></td>
<td></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></td>
<td></td>
</tr>
</tbody>
</table>
47. Continued

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7) You put your penis in her anus/butt (anal sex).</td>
<td><strong>NO</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>IF NONE, SKIP TO ITEM (10).</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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><strong>NO</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<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><strong>NO</strong></td>
<td><strong>YES</strong></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (&quot;rimming&quot;).</td>
<td><strong>NO</strong></td>
<td><strong>YES</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td><strong>NO</strong></td>
<td><strong>YES</strong></td>
</tr>
</tbody>
</table>

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

☐ No — SKI P TO Q 51

☐ Yes

49. 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.

B. With how many other men have you had sexual activity that did not include intercourse since your last visit?
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 50.13**

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

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</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>Did you do this/engage in this activity with a man since your last visit?</td>
<td></td>
</tr>
<tr>
<td>1) You put your penis in his mouth.</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF NONE, SKIP TO ITEM (4).</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>NO YES</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 YES</td>
</tr>
<tr>
<td>IF ONE PARTNER: 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 YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>NO YES</td>
</tr>
<tr>
<td>3) 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 YES</td>
</tr>
<tr>
<td>IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>NO YES</td>
</tr>
<tr>
<td>4) You put your penis in his anus/butt.</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF NONE, SKIP TO ITEM (7).</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>NO YES</td>
</tr>
<tr>
<td>5b.) 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 YES</td>
</tr>
<tr>
<td>If any unprotected anal sex (Q5b &lt; Q4) then read:</td>
<td>NO YES</td>
</tr>
<tr>
<td>For those men with whom you did not use a condom,</td>
<td>NO YES</td>
</tr>
<tr>
<td>5b.1) Were any of these men HIV positive?</td>
<td>NO YES</td>
</tr>
<tr>
<td>5b.2) Were any of these men HIV negative?</td>
<td>NO YES</td>
</tr>
<tr>
<td>If 5b.1 or 5b.2 = Don’t Know/Not Sure, skip to 6b.</td>
<td>NO YES</td>
</tr>
<tr>
<td>5b.3) Were you unsure of the HIV status of any of these men?</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td>NO YES</td>
</tr>
<tr>
<td>5a.) 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 YES</td>
</tr>
<tr>
<td>If 5a = No,</td>
<td>NO YES</td>
</tr>
<tr>
<td>5a.1) What was the HIV status of your partner when you did not use a condom?</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>NO YES</td>
</tr>
<tr>
<td>6b.) 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 YES</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td>NO YES</td>
</tr>
<tr>
<td>KIND OF ACTIVITY</td>
<td>Did you do this/engage in this activity with a man since your last visit?</td>
</tr>
<tr>
<td>------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS: 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 YES</td>
</tr>
<tr>
<td>8) Thinking of the times when a man put his penis in your mouth, was a condom used every time, even if it broke, tore, or slipped? IF ONE PARTNER:</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS: 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 YES</td>
</tr>
<tr>
<td>9) 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? IF ONE PARTNER:</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</td>
<td>NO YES</td>
</tr>
<tr>
<td>10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS: 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 YES</td>
</tr>
<tr>
<td>If any unprotected anal sex (Q11b &lt; Q10) then read: Of the men who did not use a condom, 11b.1) Were any of these men HIV positive? 11b.2) Were any of these men HIV negative? If 11b.1 or 11b.2 = Don’t Know/Not Sure, skip to 12b. 11b.3) Were you unsure of the HIV status of any of these men?</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF ONE PARTNER: Thinking of the times when he put his penis in your anus/butt, was a condom used every time, even if it broke, tore, or slipped?</td>
<td>NO YES</td>
</tr>
<tr>
<td>If 11a = No, 11a.1) What was the HIV status of your partner when he did not use a condom?</td>
<td>NO YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS: 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 YES</td>
</tr>
</tbody>
</table>
50. Continued

**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>13) You used your tongue to touch or lick his anus/butt (&quot;rimming&quot;).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Did you do this/engage in this activity with a man since your last visit?**

**How many men did you do that with (since your last visit)? (Give me the actual number) (IF NEEDED: What’s your best estimate?)**

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10
- 20
- 30
- 40
- 50
- 60
- 70
- 80
- 90
- 100
- 200
- 300
- 400
- 500
- 600
- 700
- 800
- 900
- 1000

---

**IF participant has only one man since last visit (49A + 49B = 1), ask Q 50.14 more than 1 sex partner since last visit, skip to Q 50.15**

**50.14) You said you had (intercourse or sexual activity) with only one man [(since your visit in (MONTH)]. How would you describe this individual?**

- Main partner or someone you have a longstanding relationship with, live with, or partner with
- Casual partner, one-time partner, or person with whom you have not developed a longstanding, close relationship with

**IF participant describes as main partner or someone you have a longstanding relationship with, live with, or partner with, go to Q 50.15. Otherwise, skip to Q 50.18.**

**50.15) You mentioned that you had sex with more than one man [(since your visit in (MONTH)]. Would you consider only one of these men to be a main partner or someone you have a longstanding relationship with, live with, or partner with?**

- No
- Yes

**50.16) Did you have unprotected anal intercourse with your main partner in the last 6 months?**

- No
- Yes

**50.17) What is the HIV status of your main partner?**

- Negative
- Positive
- I don’t know

**50.18) Many men meet new sexual partners through different sources and in different settings. Since your last MACS visit, have you met one or more new male sexual partners in any of the following settings?**

- a) have not met any new partners in past 6 months
- b) on the internet
- c) at a party (including a circuit party)
- d) through an advertisement in a newspaper or other newsletter
- e) at a bar
- f) at a bath house
- g) in a park or other outdoor public place
- h) in a bathroom, bookstore, or other indoor public place
- i) at a place where drugs were used or exchanged
- j) other place not listed above

**IF YES TO A, SKIP TO Q 51**

**SERIAL #**
51. 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>Yes</th>
<th>No</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></td>
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<tr>
<td>“Poppers” like nitrite inhalants (amyl, butyl or isopropyl nitrites)</td>
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<tr>
<td>Crack or cocaine that you smoke</td>
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<tr>
<td>Other forms of cocaine</td>
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<tr>
<td>Speed, Meth or Ice</td>
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<tr>
<td>Heroin</td>
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<tr>
<td>Speedball (heroin and cocaine together)</td>
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<tr>
<td>Ecstasy, XTC, X or MDMA</td>
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<tr>
<td>Other kinds of street/club drugs</td>
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</tbody>
</table>
52.A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?

- No
- Yes

B. Were any of these times that you injected recreational drugs in a shooting gallery?

- No
- Yes

C. Do you currently inject drugs?

- No
- Yes

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

- Speedball (cocaine and heroin together)
- Cocaine by itself
- Heroin by itself
- Speed by itself

53. [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
- Yes

54.A. [Since your last visit in (MONTH)] have you used needles or works that were first used by someone else and then passed to you?

- B. With how many different people?

55.A. [Since your last visit in (MONTH)] have you shared water to rinse your needles with anyone?

- No
- Yes

B. How many times?

- C. With how many different people?

56. [Since your last visit in (MONTH)] how often did you clean your works with bleach?

- Never
- Less than half the time
- About half the time
- Most of the time
- Always

57.A. [Since your last visit in (MONTH)] have you participated in a needle exchange program?

- No
- Yes

B. Of the times you obtained needles, how often did you get them from a needle exchange?

- C. Do you have another source of clean needles?

58. [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
- Yes

Interviewer Instructions:
Thank the participant.
Record the time ended on page 20.