

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

No → **IF "NO," GO TO Q 3**
 Yes
 ↓

a IF YES: What was the diagnosis?	b In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?																																																																						
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c What was the name and address of the physician who diagnosed the condition(s)?

Name of hospital/clinic or doctor

Address

City State

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Address

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*** 3. Since your last visit [in (MONTH, YEAR)], were you diagnosed with pneumonia?**

No → **IF "NO," GO TO Q 4**
 Yes
 ↓

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

	J	F	M	A	M	J	J	A	S	O	N	D
	97	98	99	00	01	02	03	04	05	06	07	08

b What was the name and address of the physician who diagnosed the condition?

Name of hospital/clinic or doctor

Address

City State

Clinician's Notes: Method of Diagnosis

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

* 4.A. Since your last visit [in (MONTH, YEAR)], did you have a skin test for TB, sometimes called a PPD? NO YES

SKIP TO Q 5

B. IF YES: When was your last test?

		J	F	M	A	M	J	J	A	S	O	N	D
		97	98	99	00	01	02	03	04	05	06	07	08

C. Was it positive? NO YES

* 5.A. Since your last visit [in (MONTH, YEAR)] have you had an active TB infection? NO YES

SKIP TO Q 6

B. Was the TB in your lungs?

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

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

No → **SKIP TO Q 7**

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

		0	10	20	30	40	50	60	70	80	90
		0	1	2	3	4	5	6	7	8	9

GET MEDICAL RELEASE

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL. IF HOSPITALIZED FOR CV CONDITION, REQUEST FULL HOSPITAL RECORDS. SEE GUIDELINES FOR SPECIFIC INSTRUCTIONS.

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	S	O	N	D
DAY		0	10	20	30								
		0	1	2	3	4	5	6	7	8	9		
YEAR		97	98	99	00	01	02	03	04	05	06	07	08

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

		0	10	20	30	40	50	60	70	80	90
		0	1	2	3	4	5	6	7	8	9

NIGHTS

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

<p>What was the name and address of the physician who diagnosed the condition(s)? IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE</p> <p>Name of hospital/clinic or doctor _____</p> <p>Address _____</p> <p>City _____ State _____</p>	<table style="width: 100%;"> <tr> <td style="width: 60%; height: 60px; vertical-align: top;">1) Diagnosis or procedure</td> <td style="width: 40%; text-align: center;"> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;">V</td> <td style="width: 20px; height: 20px;">E</td> <td style="width: 20px; height: 20px;">P</td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px;">0</td><td style="width: 20px; height: 20px;">1M</td><td style="width: 20px; height: 20px;">2M</td><td style="width: 20px; height: 20px;">3M</td><td style="width: 20px; height: 20px;">4M</td><td style="width: 20px; height: 20px;">5M</td><td style="width: 20px; height: 20px;">6M</td><td style="width: 20px; height: 20px;">7M</td><td style="width: 20px; 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IF ONLY ONE HOSPITALIZATION (SEE RESPONSE TO 6.A.), SKIP TO QUESTION 7

(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	S	O	N	D
DAY		0	10	20	30								
		0	1	2	3	4	5	6	7	8	9		
YEAR		97	98	99	00	01	02	03	04	05	06	07	08

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

	0	10	20	30	40	50	60	70	80	90	NIGHTS
	0	1	2	3	4	5	6	7	8	9	

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

RECORD FULLY IN R's OWN WORDS.

What was the name and address of the physician who diagnosed the condition(s)? IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE	1) Diagnosis or procedure	V	E	P							
		0	1M	2M	3M	4M	5M	6M	7M	8M	9M
Name of hospital/clinic or doctor Address City _____ State _____	2) Diagnosis or procedure	V	E	P							
		0	1M	2M	3M	4M	5M	6M	7M	8M	9M
		0	100	200	300	400	500	600	700	800	900
		0	10	20	30	40	50	60	70	80	90
		0	1	2	3	4	5	6	7	8	9

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

No → **SKIP TO Q 7**
 Yes

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

7. Since your last visit [in (MONTH, YEAR)], 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?**

	J	F	M	A	M	J	J	A	S	O	N	D
	97	98	99	00	01	02	03	04	05	06	07	08

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.

Since your last visit [in (MONTH, YEAR)], have any members of your immediate blood-related family been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?

No
 Yes
 Don't know
 Not applicable (For those participants who do not have living blood-related family members or do not know them because they are adopted.)

→ **SKIP TO Q 9.A.(1)**

8.B. Since your last visit [in (MONTH, YEAR)], have any members of your immediate family been diagnosed with...

	NO	YES	DON'T KNOW
a. high blood pressure or hypertension?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. angina, which often causes chest pain?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. a heart attack or myocardial infarction (MI) before age 55?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. congestive heart failure or CHF?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. a stroke or CVA?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. mini-strokes or transient ischemic attacks (TIA)?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. high cholesterol, high triglycerides, high lipids or too much fat in their blood?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. high blood sugar or diabetes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

8.C. Since your last visit [in (MONTH, YEAR)], have any members of your immediate family been diagnosed with cancer?

No Yes Don't Know → **SKIP TO Q 9.A.(1)**
 No → **SKIP TO Q 9.A.(1)**

IF YES: Was it:

	NO	YES	DON'T KNOW
a. Skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Colon cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Prostate cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Cervical cancer (female family members)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Anal cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Other cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify:

* 9.A.(1) Since your last visit [in (MONTH, YEAR)], have you undergone an anal pap smear? (A doctor or medical practitioner took a swab of the anal canal to test for cancer cells.)

No → **GO TO Q 9.B**
 Yes
 Don't Know → **GO TO Q 9.B**

(2) In what month and year did you have the pap smear performed?

	J	F	M	A	M	J	J	A	S	O	N	D
	97	98	99	00	01	02	03	04	05	06	07	08

(3) Were the results abnormal?

No → **GO TO Q 9.B**
 Yes → **GET MEDICAL RELEASE**
 Unable to evaluate/don't know → **GET MEDICAL RELEASE**

Name of the doctor who performed the pap smear and where it was performed.

Name of doctor _____

Name of hospital/center/clinic _____

City _____ State _____

SERIAL #

9.B. Since your last visit [in (MONTH, YEAR)], has a doctor or medical practitioner inserted a tube-shaped device or scope in your anus or rectum to look for hemorrhoids, fissures, infections and some cancers?

- No
- Yes
- Don't Know

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

- No
- Yes

REVIEW RESPONSE TO Q 1, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 10

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

	1	2	3	4	5	6	7	8	9	TIMES
--	---	---	---	---	---	---	---	---	---	-------

(3) For each biopsy, please tell me:

a Where in your body?	b What did they say the diagnosis or result of the biopsy was?	c Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy.																																								
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GET MEDICAL RELEASE

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

	NO	YES
A. Shingles	<input type="radio"/>	<input type="radio"/>
B. Thrush (yeast in your mouth)	<input type="radio"/>	<input type="radio"/>
C. Sinusitis, a sinus infection that requires antibiotics	<input type="radio"/>	<input type="radio"/>
D. Bronchitis	<input type="radio"/>	<input type="radio"/>
E. Pancreatitis	<input type="radio"/>	<input type="radio"/>
F. Prostate problems (not cancer)	<input type="radio"/>	<input type="radio"/>
G. Erectile dysfunction (erectile problems)	<input type="radio"/>	<input type="radio"/>
H. High blood pressure or hypertension	<input type="radio"/>	<input type="radio"/>
I. Anemia, low RBC, low hemoglobin	<input type="radio"/>	<input type="radio"/>
J. High cholesterol, high triglycerides, high lipids or too much fat in your blood	<input type="radio"/>	<input type="radio"/>
K. High blood sugar or diabetes	<input type="radio"/>	<input type="radio"/>
L. Arthritis	<input type="radio"/>	<input type="radio"/>
IF YES: Was it: <input type="checkbox"/> Rheumatoid	<input type="radio"/>	<input type="radio"/>
(Read and answer each.) <input type="checkbox"/> Osteoarthritis or degenerative	<input type="radio"/>	<input type="radio"/>
<input type="checkbox"/> Other	<input type="radio"/>	<input type="radio"/>
Specify:		
	<input type="radio"/>	<input type="radio"/>

*M. Angina or chest pain caused by your heart	<input type="radio"/>	<input type="radio"/>
*N. Heart attack or myocardial infarction (MI)	<input type="radio"/>	<input type="radio"/>
*O. Congestive heart failure or CHF	<input type="radio"/>	<input type="radio"/>
*P. Stroke or Cerebrovascular accident (CVA)	<input type="radio"/>	<input type="radio"/>
*Q. Mini-strokes or transient ischemic attacks (TIA)	<input type="radio"/>	<input type="radio"/>
*R. Too fast, too slow, or irregular heart beat	<input type="radio"/>	<input type="radio"/>
*S. Any blood vessels (arteries) that were blocked or closed IF NO, SKIP TO Q U	<input type="radio"/>	<input type="radio"/>
*T. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas	<input type="radio"/>	<input type="radio"/>
*U. A blood clot in your legs	<input type="radio"/>	<input type="radio"/>
*V. A blood clot in your lungs	<input type="radio"/>	<input type="radio"/>
*W. Seizure or convulsions	<input type="radio"/>	<input type="radio"/>
*X. Osteoporosis (bone thinning)	<input type="radio"/>	<input type="radio"/>
*Y. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis	<input type="radio"/>	<input type="radio"/>
*Z. Kidney disease/Renal failure	<input type="radio"/>	<input type="radio"/>

GET MEDICAL RELEASE IF BOLD

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 _____

IF ADDITIONAL DOCTOR INFORMATION IS NEEDED, RECORD IN Q30.B ON PAGE 20.

* **AA. Liver disease** NO YES

IF YES: Was it: 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 _____

Date of diagnosis _____

BB. Since your last visit [in (MONTH, YEAR)], have you received the injections of the combination vaccine for the prevention of Hepatitis A and B?

No Yes Don't Know

SKIP TO Q EE.

CC. Since your last visit [in (MONTH, YEAR)], have you received injections or a vaccine for the prevention of Hepatitis A?

No Yes Don't Know

DD. Since your last visit [in (MONTH, YEAR)], have you received injections or a vaccine for the prevention of Hepatitis B?

No Yes Don't Know

* **EE. Since your last visit [in (MONTH, YEAR)], have you had any neurological evaluation or a physical examination to look for problems of the nervous system (brain, spinal cord, nerves in hands and feet)?** NO YES

IF YES: Was there a diagnosis for your condition? NO YES

IF YES: What was the diagnosis?

Specify: _____

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

GO TO PAGE 20 TO RECORD ADDITIONAL DOCTORS' NAMES/ADDRESSES.

SERIAL #

FF. Since your last visit [in (MONTH, YEAR)], have you seen a doctor or other medical practitioner for any **OTHER NEW** conditions or problems in the following areas?

a) Eyes

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

Specify:

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

NO YES
SKIP TO b

b) Ears, Nose, Throat, Mouth and Sinuses

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

Specify:

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

NO YES
SKIP TO c

c) Heart and Blood Vessels

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

Specify:

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

NO YES
SKIP TO d

GET MEDICAL RELEASE

d) Lungs and Bronchial Tubes

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

Specify:

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

NO YES
SKIP TO e

e) Stomach and Intestines

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

Specify:

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

NO YES
SKIP TO f

f) Bones, Joints or Muscles

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

Specify:

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

NO YES
SKIP TO g

g) Genital, Urinary and Rectal

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

Specify:

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

NO YES
SKIP TO h

h) Skin

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

Specify:

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

NO YES
SKIP TO i

i) Nervous system

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

Specify:

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

NO YES
SKIP TO j

GET MEDICAL RELEASE

j) Psychological

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

Specify:

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

NO YES
SKIP TO k

FF. Continued

k) Hormones or Endocrine system

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

NO YES

SKIP TO I

Specify:

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

l) Blood

GET MEDICAL RELEASE

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

NO YES

SKIP TO m

Specify:

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

m) Allergy and Immune system other than HIV infection

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

NO YES

SKIP TO n

Specify:

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

n) Other

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

NO YES

SKIP TO Q11.A

1.

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

2.

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

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

Name of hospital/clinic or doctor

Address

City

State

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

- | | | |
|---|-----------------------|-----------------------|
| 1) Facial herpes, cold sores, or fever blisters | <input type="radio"/> | <input type="radio"/> |
| 2) Sores in genital region | <input type="radio"/> | <input type="radio"/> |
| 3) Sores in the anal or rectal areas | <input type="radio"/> | <input type="radio"/> |
| 4) Sores elsewhere on your body | <input type="radio"/> | <input type="radio"/> |

IF "NO" TO ALL FOUR, SKIP TO Q 12

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

C. Has there been a period since your last visit [in (MONTH, YEAR)] 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 last visit [in (MONTH, YEAR)]? How about (EACH)?

DISEASE OR CONDITION	HAD DISEASE	
	NO	YES

A.1) Syphilis

IF "NO," SKIP TO (B)

A.2) Was this a new infection or was it a continuation or relapse of a previous infection?

- New infection
 Continued or relapse

B) Any form of gonorrhea

IF "NO" TO (B), SKIP TO (F)

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 or chlamydia (that is, a discharge from the penis that's not caused by gonorrhea)

G.1) Genital warts (condylomata acuminata)

IF "NO," SKIP TO (H)

G.2) Was this a new infection or was it a continuation or relapse of a previous infection?

- New infection
 Continued or relapse

H.1) Anal warts (condylomata acuminata)

IF "NO," SKIP TO (I)

H.2) Was this a new infection or was it a continuation or relapse of a previous infection?

- New infection
 Continued or relapse

I) Any other diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis

Specify:

SERIAL #

13.A. Since your last visit [in (MONTH, YEAR)], have you had any of the following problems or symptoms?
 This includes those due to illnesses or side effects from medications.

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, e, AND f.	a How about (EACH)? Did you have that at any time since your last visit [in (MONTH, YEAR)]?		b Did that last for two weeks or longer?		c And do you have that now?		d Did you experience this symptom due to taking any medication?			e Is this a new condition? IF YES, GO TO COLUMN F		f In what month and year since your last visit [in (MONTH, YEAR)] 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)].
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES	
1) Persistent dizziness for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
7) Diarrhea for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
8) Drenching sweats at night on at least 3 occasions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
9) Nausea, vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
10) Abdominal pain, bloating, cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
11) Ascites (fluid buildup in the stomach or abdomen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
13) An unusual bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
15) Unusual bleeding or bleeding that is difficult to stop	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08

13.A. Continued

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, e, AND f.	a How about (EACH)? Did you have that at any time since your last visit [in (MONTH, YEAR)]?		b Did that last for two weeks or longer?		c And do you have that now?		d Did you experience this symptom due to taking any medication?			e Is this a new condition? IF YES, GO TO COLUMN F		f In what month and year since your last visit [in (MONTH, YEAR)] 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)].
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES	
16) Muscle pain or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
17) Joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
18) Painful urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
19) Blood in urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
20) Kidney stones	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
21) Vivid nightmares or dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08
22) Insomnia or problems sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 97 98 99 00 01 02 03 04 05 06 07 08

13.B. Since your last visit [in (MONTH, YEAR)], have you experienced:

	If NO, go to next question. If YES, indicate severity.			Severity (0= None, 1= Mild, 10= Severe)											Did you experience this symptom due to taking any medication?			
	NO	YES		NO	YES	DON'T KNOW												
1. Pain, aching, or burning in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2. Pins and needles in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3. Numbness (lack of feeling) in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
			Left	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

If the participant reports bleeding with pain (Q13.C(2) = YES), inform your clinic coordinator immediately following the interview.

13.C.(1) Since your last visit [in (MONTH, YEAR)], did you experience anal bleeding at any time?

(If participant asks why: "The information that we gather about symptoms will help researchers learn how symptoms are related to the risk of developing certain illnesses or diseases. Understanding this relationship will help doctors and nurses do a better job in detecting and diagnosing illnesses.")

- No → **GO TO Q 14**
 Yes

13.C.(2) Since your last visit [in (MONTH, YEAR)], have you experienced any pain with the anal bleeding?

- No → **GO TO Q 13.C.(4)**
 Yes

13.C.(3) Since your last visit [in (MONTH, YEAR)], how often have you experienced pain with the anal bleeding?

- Rarely
 Some of the time
 Most of the time
 All of the time

13.C.(4) Since your last visit [in (MONTH, YEAR)], has the bleeding occurred in any of the following situations?
[READ EACH ITEM]

	NO	YES
a) After or during anal receptive intercourse	<input type="radio"/>	<input type="radio"/>
b) After or during a bowel movement	<input type="radio"/>	<input type="radio"/>
c) Other times not associated with intercourse or bowel movements	<input type="radio"/>	<input type="radio"/>

IF NO ANAL BLEEDING IN OTHER TIMES (Q13.C.(4)c = NO), GO TO Q14.

13.C.(5) With respect to the *other times* (that you have had anal bleeding), how often have you experienced bleeding since your last visit [in (MONTH, YEAR)]?

- Daily
 Weekly
 Monthly
 Less than monthly

* 14. Since your last visit, [in (MONTH, YEAR)], 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
 Yes → **SKIP TO Q 15.A.(1)**

14.A IF NO: Why did you decide not to take HIV-related medications? **READ EACH, MARK ALL THAT APPLY.**

Not infected with HIV → **GO TO Q 16**
 Doctor said was not necessary
 Not sick
 Too expensive
 Don't think they work or will help
 Possible side effects
 Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
 Other reason

Specify:

15.A.(1) Since your last visit [in (MONTH, YEAR)], has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs? I am referring to the types of HIV drug resistance tests that are called genotyping or phenotyping.

No → **SKIP TO Q 15.B.(1) IF ON HIV MEDS SINCE LAST VISIT**
 Yes → **SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT**

(2) Has your treatment (drugs) been changed as a result of that test? No Yes Don't know

SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT

* 15.B.(1) Since your last visit [in (MONTH, YEAR)], have you taken any medication or drug on this list [SHOW LIST 1 AND MEDICATION PHOTO CARDS]?

No
 Yes → **SKIP TO Q 15.B.(3)**

(2) IF NO: Why did you decide not to take HIV-related medications?

READ EACH, MARK ALL THAT APPLY AND THEN SKIP TO Q 15.C

Doctor said was not necessary
 Not sick
 Too expensive
 Don't think they work or will help
 Possible side effects
 Can't take them the way the doctor wants (too many pills, too many times during the day or won't remember to take them)
 Other reason

Specify:

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) AND THEN COMPLETE FORM 1 FOR EACH DRUG.

- abacavir (Ziagen) (218)
- amprenavir (Agenerase) (219)
- atazanavir (Reyataz) (243)
- Combivir (zidovudine + lamivudine) (227)
- d4T (Zerit, Stavudine) (159)
- delavirdine (Rescriptor) (194)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- enfuvirtide (Fuzeon, T-20, pentafuside) (233)
- Epzicom (abacavir + lamivudine) (254)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- lamivudine (EpiVir, 3TC) (204)
- lopinavir (Kaletra) (217)
- nelfinavir (Viracept) (216)
- nevirapine (Viramune) (191)
- ritonavir (Norvir) (211)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- tipranavir (238)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Truvada (emtricitabine + tenofovir) (253)
- zidovudine (Retrovir, AZT) (092)
- Other anti-retroviral from Drug List 1 → **Report Acyclovir in Q 16.**

1.

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

2.

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

3.

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

(4) Since your last visit [in (MONTH, YEAR)], did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?

No → **SKIP TO Q 15.C**
 Yes

IF YES: How many times did this occur?

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Did your physician prescribe or agree to any of these?
 No Yes

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

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

SERIAL #

* 15.C.(1) Since your last visit [in (MONTH, YEAR)], 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.

- | | |
|---|--|
| <input type="radio"/> atovaquone (Mepron, BW566C80) (190) | <input type="radio"/> ganciclovir (Cytovene, DHPG, valcyte, valganciclovir) (125) |
| <input type="radio"/> azithromycin (Zithromax) (152) | <input type="radio"/> interleukin 2 (IL-2) (096) |
| <input type="radio"/> Bactrim (Septra, TMP/SMX) (112) | <input type="radio"/> Marinol (dronabinol) (547) |
| <input type="radio"/> ciprofloxacin (Cipro) (153) | <input type="radio"/> Megace (megestrol acetate) (123) |
| <input type="radio"/> clarithromycin (Biaxin) (184) | <input type="radio"/> NAC (N-acetyl cysteine) (188) |
| <input type="radio"/> co-enzyme Q (196) | <input type="radio"/> Nandrolone (deca-durabolin) (232) |
| <input type="radio"/> colony stimulating factor (G-CSF, Neupogen) (157) | <input type="radio"/> Oxandrin (oxandrolone) (228) |
| <input type="radio"/> dapsone (113) | <input type="radio"/> rifabutin (Mycobutin, Ansamycin) (093) |
| <input type="radio"/> DHEA (dihydroepiandrosteronedione) (161) | <input type="radio"/> Serostim (human growth hormone) (245) |
| <input type="radio"/> erythropoietin (Epogen, Procrit, Aranesp) (117) | <input type="radio"/> testosterone (Androgel, Androderm, Delatestryl, Striant, Testoderm, Virilon) (236) |
| <input type="radio"/> ethambutol (Myambutol) (137) | |
| <input type="radio"/> fluconazole (Diflucan) (116) | |
| <input type="radio"/> foscarnet (foscavir) (091) | |

Other from Drug List 2 (Report Acyclovir in Q 16.)

1.

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

2.

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

3.

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

* 15.D.(1) Since your last visit [in (MONTH, YEAR)], 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**
 Yes

Interviewer: This question applies to meds not on Drug Form 2 list. No need to complete a Drug Form 2 for these drugs.

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

1. <input type="text"/>	2. <input type="text"/>	3. <input type="text"/>																																																																																																			
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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 last visit [in (MONTH, YEAR)].

<p>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)</p> <p>IF "NO" TO <u>a</u> GO TO NEXT ITEM</p>	<p>a</p> <p>How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?</p>	<p>b</p> <p>When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?</p>	<p>c</p> <p>Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</p>
		NO YES	NO YES
1) Steroids that you took by mouth or were injected	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
2) Thyroid hormone or thyroid medication	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
3) Other hormones such as anabolic steroids	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
5) Medication taken by mouth for fungal infection	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
6) Medication taken by mouth for worms or parasites	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
7) Tranquilizers or sleeping pills	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
8) Antidepressants or mood elevators	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
9) Lithium	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it: Everyday? <input type="radio"/> No <input type="radio"/> Yes Only when you had active lesions or had an outbreak? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
11) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES
12) Aspirin taken three days or more on a weekly basis	<input type="radio"/> NO <input type="radio"/> YES	Name: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES

SERIAL #

16. Continued	ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)	a How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	b When specified, what was the name of the (KIND OF DRUG) you took?	c Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?																																												
	IF "NO" TO a GO TO NEXT ITEM	NO YES <input type="radio"/> <input type="radio"/> SKIP TO Q 16.14	Name: 	NO YES <input type="radio"/> <input type="radio"/>																																												
13) Medications to lower cholesterol, triglycerides, lipids or blood fat	a. <table border="1"> <tr><td></td><td>0</td><td>1000</td><td>2000</td><td>3000</td><td>4000</td><td>5000</td><td>6000</td><td>7000</td><td>8000</td><td>9000</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	NO YES <input type="radio"/> <input type="radio"/> SKIP TO Q 16.14	Name: 	NO YES <input type="radio"/> <input type="radio"/>
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16. Continued ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a). IF "NO" TO a GO TO Q17.A.

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Have you (taken/used) any other medications since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	What did you take this drug for?	Have you taken/used any in the past 5 days?																																												
<p>17) Other</p> <p>a. NO YES <input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <table border="1"> <tr><td></td><td>0</td><td>1000</td><td>2000</td><td>3000</td><td>4000</td><td>5000</td><td>6000</td><td>7000</td><td>8000</td><td>9000</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>Used for:</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>
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17.A. Since your last visit [in (MONTH, YEAR)], 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:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
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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 [in (MONTH, YEAR)], have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

No → **SKIP TO Q 18.A9**

Yes - did you have

NO YES

- 1) Coverage by an HMO NO YES
- 2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) NO YES
- 3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) NO YES
- 4) Medicaid, Medi-Cal, or Medical Assistance NO YES
- 5) Medicare (for people over 65 or permanently disabled) NO YES
- 6) Health care benefits for The Armed Forces or Veteran's Administration NO YES
- 7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans NO YES

8) Other NO YES

Specify:

9) ADAP (AIDS Drug Assistance Program) NO YES

B. Do you have insurance coverage that pays for any of your medications? NO YES

IF NO TO Q 18.A AND NO TO Q 18.B, THEN SKIP TO Q 22

19. Are you currently insured?

No Yes

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

SERVICE	a Have you used (EACH) since your last visit [in (MONTH, YEAR)]?	b How many times? (99 = 99 or more)																						
1) Dental health care provider (such as dentist or dental hygienist)	<input type="radio"/> NO GO TO NEXT ROW <input type="radio"/> YES	<table border="1"> <tr> <td></td> <td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)	<input type="radio"/> NO GO TO NEXT ROW <input type="radio"/> YES	<table border="1"> <tr> <td></td> <td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist, masseuse, dietitian)	<input type="radio"/> NO GO TO NEXT ROW <input type="radio"/> YES	<table border="1"> <tr> <td></td> <td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)	<input type="radio"/> NO GO TO Q 26 <input type="radio"/> YES	<table border="1"> <tr> <td></td> <td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td> </tr> <tr> <td></td> <td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td> </tr> </table>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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34.

Abbreviated interview

- No
- Yes

35.

Date interview completed

TIME ENDED				
HR		MIN		
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<input type="radio"/> 10	<input type="radio"/> 1	<input type="radio"/> 10	<input type="radio"/> 1	AM
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<input type="radio"/> 4	<input type="radio"/> 40	<input type="radio"/> 4	<input type="radio"/> 0	PM
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<input type="radio"/> 9	<input type="radio"/>	<input type="radio"/> 9	<input type="radio"/>	

36.

Interviewer's signature

INTERVIEWER'S NUMBER										
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ACASI begins here.

37. 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

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

- No → **SKIP TO Q 39**
- Yes

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

- Less
- Same
- Greater

39. Since your last visit [in (MONTH, YEAR)], has your employment status changed for any reason related to HIV disease?

- No → **SKIP TO Q 40**
- Yes

IF YES: ASK: What were the reasons? (READ EACH ITEM)

	NO	YES
1) Became too sick to work	<input type="radio"/>	<input type="radio"/>
2) HIV status became known to employer	<input type="radio"/>	<input type="radio"/>
3) HIV status became known to coworkers	<input type="radio"/>	<input type="radio"/>
4) Early retirement	<input type="radio"/>	<input type="radio"/>
5) Changed job as a personal decision	<input type="radio"/>	<input type="radio"/>
6) To receive better health insurance benefits	<input type="radio"/>	<input type="radio"/>
7) To receive better disability benefits	<input type="radio"/>	<input type="radio"/>
8) Other	<input type="radio"/>	<input type="radio"/>

Specify:

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

40. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes?

- No → **SKIP TO Q 41**
 Yes

B. Do you smoke cigarettes now? (As of one month ago?)

- No → **SKIP TO Q 41**
 Yes
 Occasionally (less than one cigarette per day)
↳ **SKIP TO Q 41**

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

41. 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 → **STOP – SKIP TO Q 41K**
 Less than monthly Weekly
 Monthly Daily or almost daily

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 5 or 6 10 or more
 3 or 4 7 to 9 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 Monthly Daily or almost daily
 Less than monthly Weekly

D. How often during the past 6 months have you found that you were not able to stop drinking once you started?

- Never Monthly Daily or almost daily
 Less than monthly Weekly

E. How often during the past 6 months have you failed to do what was normally expected from you because of drinking?

- Never Monthly Daily or almost daily
 Less than monthly Weekly

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 Monthly Daily or almost daily
 Less than monthly Weekly

G. How often during the past 6 months have you had a feeling of guilt or remorse after drinking?

- Never Monthly Daily or almost daily
 Less than monthly Weekly

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 Monthly Daily or almost daily
 Less than monthly Weekly

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. Since your last visit [in (MONTH, YEAR)], have you been in an alcohol treatment program, including inpatient and/or outpatient detox, alcoholics anonymous, and/or any other program?

- 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.

42. Have you engaged in any sort of sexual activities involving another person since your last visit [in (MONTH, YEAR)]?

- No → **SKIP TO Q 49**
 Yes

43. Have you had any sexual activity with a woman since your last visit [in (MONTH, YEAR)]?

- No → **SKIP TO Q 46**
 Yes

GO TO QUESTION 44 ON NEXT PAGE.

44. Now lets talk about how many different women you have had sexual activity with since your last visit [in (MONTH, YEAR)].

A. How many different women (if any) have you had sexual intercourse with since your last visit [in (MONTH, YEAR)]? Here we define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus/butt, with or without ejaculation.

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

B. With how many (other) women have you had sexual activity that did not include intercourse since your last visit [in (MONTH, YEAR)]?

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

IF ONLY 1 PARTNER (Q 44.A + Q 44.B = 1), GO TO Q 44.C.1

IF MORE THAN 1 PARTNER (Q 44.A + Q 44.B ≥ 2), GO TO Q 44.C.2

C.1) You said you had intercourse or sexual activity with only one woman since your last visit [in (MONTH, YEAR)]. How would you describe this woman?

- Main partner or someone you have a longstanding relationship with, live with, or partner with. → **GO TO Q 44.D**
- Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with. → **GO TO Q 45.1a**

C.2) You mentioned that you had intercourse or sexual activity with more than one woman since your last visit [in (MONTH, YEAR)]. A main partner is defined as a partner you have a longstanding relationship with, live with, or partner with. Would you consider one of these women to be your main partner?

- No → **GO TO Q 45.1b** Yes → **GO TO Q 44.D**

D. Did you have unprotected vaginal or anal intercourse with your main partner since your last visit [in (MONTH, YEAR)]?

- No Yes

E. What is the HIV status of your main partner?

- Negative Positive Don't Know

45. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																																	
<p>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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	0	1	2	3	4	5	6	7	8	9																									
<p>IF MULTIPLE PARTNERS: 8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>IF MULTIPLE PARTNERS: 9) With how many women did you ejaculate/cum in their anus/butt when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>10) You used your tongue to touch or lick her anus/butt ("rimming").</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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46. Have you had any sort of sexual activity with a man since your last visit [in (MONTH, YEAR)]?

No → **SKIP TO Q 48.18**

Yes

↓

47. Now lets talk about how many different men you have had sexual activity with since your last visit [in (MONTH, YEAR)].

A. How many different men (if any) have you had sexual intercourse with since your last visit [in (MONTH, YEAR)]? Here we define sexual intercourse as follows: you put your penis in your partner's mouth or anus/butt—or your partner put his penis in your mouth or anus/butt, with or without ejaculation.

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

B. With how many (other) men have you had sexual activity that did not include intercourse since your last visit [in (MONTH, YEAR)]?

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

IF ONLY 1 PARTNER (Q 47.A + Q 47.B = 1), GO TO Q 47.C.1

IF MORE THAN 1 PARTNER (Q 47.A + Q 47.B ≥ 2), GO TO Q 47.C.2

47. Continued

C.1) You said you had intercourse or sexual activity with only one man since your last visit [in (MONTH, YEAR)]. How would you describe this man?

- Main partner or someone you have a longstanding relationship with, live with, or partner with. → **GO TO Q 47.D**
- Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with. → **GO TO Q 48.1a**

C.2) You mentioned that you had intercourse or sexual activity with more than one man since your last visit [in (MONTH, YEAR)]. A main partner is defined as a partner you have a longstanding relationship with, live with, or partner with. Would you consider one of these men to be your main partner?

- No → **GO TO Q 48.1b**
- Yes → **GO TO Q 47.D**

D. Did you have unprotected anal intercourse with your main partner since your last visit [in (MONTH, YEAR)]?

- No
- Yes

E. What is the HIV status of your main partner?

- Negative
- Positive
- Don't Know

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 48.13

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																																	
1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (4).	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"> </td><td style="width: 20px;">0</td><td style="width: 20px;">100</td><td style="width: 20px;">200</td><td style="width: 20px;">300</td><td style="width: 20px;">400</td><td style="width: 20px;">500</td><td style="width: 20px;">600</td><td style="width: 20px;">700</td><td style="width: 20px;">800</td><td style="width: 20px;">900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in their mouth, with how many of those men did you use a condom every time, even if it broke, tore, or slipped? 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?	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"> </td><td style="width: 20px;">0</td><td style="width: 20px;">100</td><td style="width: 20px;">200</td><td style="width: 20px;">300</td><td style="width: 20px;">400</td><td style="width: 20px;">500</td><td style="width: 20px;">600</td><td style="width: 20px;">700</td><td style="width: 20px;">800</td><td style="width: 20px;">900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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	0	10	20	30	40	50	60	70	80	90																									
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IF MULTIPLE PARTNERS: 3) With how many men did you ejaculate/cum in their mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?	NO YES <input type="radio"/> <input type="radio"/>	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 20px;"> </td><td style="width: 20px;">0</td><td style="width: 20px;">100</td><td style="width: 20px;">200</td><td style="width: 20px;">300</td><td style="width: 20px;">400</td><td style="width: 20px;">500</td><td style="width: 20px;">600</td><td style="width: 20px;">700</td><td style="width: 20px;">800</td><td style="width: 20px;">900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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48. Continued

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																																	
<p>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>IF MULTIPLE PARTNERS: 5b.) Thinking of the times you put your penis in their anus/butt, with how many of those men did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p>If any unprotected anal sex (Q5b < Q4) then read: For those men with whom you did not use a condom, 5b.1) Were any of these men HIV positive? 5b.2) Were any of these men HIV negative? If 5b.1 or 5b.2 = Don't Know/Not Sure, skip to 6b. 5b.3) Were you unsure of the HIV status of any of these men?</p> <p>IF ONE PARTNER: 5a.) Thinking of the times you put your penis in his anus/butt, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p>If 5a = No, 5a.1) What was the HIV status of your partner when you did not use a condom?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p> <p>NEG. POS. DON'T KNOW/NOT SURE <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> <p>DON'T KNOW/NOT SURE NO YES 5b.1) <input type="radio"/> <input type="radio"/> <input type="radio"/> 5b.2) <input type="radio"/> <input type="radio"/> <input type="radio"/> 5b.3) <input type="radio"/> <input type="radio"/></p>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>IF MULTIPLE PARTNERS: 6b.) With how many men did you ejaculate/cum in their anus/butt when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: 6a.) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>IF MULTIPLE PARTNERS: 8) Thinking of the times when a man put his penis in your mouth, with how many of those men was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times when he put his penis in your mouth, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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<p>IF MULTIPLE PARTNERS: 9) With how many men did ejaculate/cum go into your mouth when they did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
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	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									

48. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																																	
<p>10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
<p>IF MULTIPLE PARTNERS: 11b.) Thinking of the times when a man put his penis in your anus/butt, with how many of those men was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p> <p>If any unprotected anal sex (Q11b < 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?</p> <p>IF ONE PARTNER: 11a.) Thinking of the times when he put his penis in your anus/butt, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p> <p>If 11a = No, 11a.1) What was the HIV status of your partner when he did not use a condom?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p> <p>NEG. POS. DON'T KNOW/NOT SURE <input type="radio"/> <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> <p>11b.1) <input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p>11b.2) <input type="radio"/> <input type="radio"/> <input type="radio"/></p> <p>11b.3) <input type="radio"/> <input type="radio"/></p>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
<p>IF MULTIPLE PARTNERS: 12b.) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: 12a.) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
<p>13) You used your tongue to touch or lick his anus/butt ("rimming").</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									

48.18) Have you met any new partners to engage in any type of sexual activity since your last visit [in (MONTH, YEAR)]?

No → **SKIP TO Q 49**
 Yes

48.19) Since your last visit [in (MONTH, YEAR)], have you met one or more new male or female sexual partners in any of the following settings?

	NO	YES
a) on the internet	<input type="radio"/>	<input type="radio"/>
b) at a party (including a circuit party)	<input type="radio"/>	<input type="radio"/>
c) through an advertisement in a newspaper or other newsletter	<input type="radio"/>	<input type="radio"/>
d) at a bar	<input type="radio"/>	<input type="radio"/>
e) at a bath house	<input type="radio"/>	<input type="radio"/>
f) in a park or other outdoor public place	<input type="radio"/>	<input type="radio"/>
g) in a bathroom, bookstore, or other indoor public place	<input type="radio"/>	<input type="radio"/>
h) at a place where drugs were used or exchanged	<input type="radio"/>	<input type="radio"/>
i) other place not listed above	<input type="radio"/>	<input type="radio"/>

49. 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 last visit [in (MONTH, YEAR)]?

	a How about (EACH) Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?		b How often did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]?				c How did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]? [Mark all that apply.]				
	NO	YES	DAILY	WEEKLY	MONTHLY	LESS OFTEN	SNORTED	SWALLOWED	PUT IN ANUS ("booty bumped")	SMOKED	INJECTED (intravenous use)
Pot, Marijuana or Hash	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Crack or cocaine that you smoke	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Other forms of cocaine	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>		<input type="radio"/>
Speed, Meth or Ice	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speedball (heroin and cocaine together)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy, XTC, X or MDMA	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction (Show list of performance enhancing drugs to prompt and assist with recall.)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Other kinds of street/club drugs	NO <input type="radio"/>	YES <input type="radio"/>									
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					
Specify:			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>					

IF NO INJECTING DRUG USE (Q 49.c injected=NO), SKIP TO Q 56

50.A. You mentioned that since your last visit [in (MONTH, YEAR)] you have injected recreational drugs. Were any of these times that you injected recreational drugs in a shooting gallery?

- No
- Yes

B. Do you currently inject drugs?

- No
- Yes

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

Speedball (cocaine and heroin together)

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Cocaine by itself

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Heroin by itself

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

Speed by itself

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

51. Since your last visit [in (MONTH, YEAR)], have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?

- No → **SKIP TO Q 53**
- Yes

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

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

B. With how many different people?

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

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

- No → **SKIP TO Q 54**
- Yes

B. How many times?

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

C. With how many different people?

	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

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

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

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

- No → **SKIP TO Q 56**
- Yes

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

- Less than half the time
- Half the time
- Most of the time
- Always

C. Do you have another source of clean needles?

- No
- Yes

56. Since your last visit [in (MONTH, YEAR)], 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 23.

PLEASE DO NOT WRITE IN THIS AREA

