

Visit 59 CADI Form

Instructions: This form is to be used as a paper back-up for the CADI. Fill out the responses on this form and data enter the responses into the CADI by initiating a CADI session for this MACSID. Since the date and time began and ended are automatically populated by the CADI, scan in this front page and the time ended and email to Katelyn Grabowski (kgrabows@jhsphe.edu). CAMACS will update the CADI session for the MACSID with the correct dates and times. Keep a copy of each completed CADI paper form for your records.

* = abbreviated interview questions.

* MACSID NUMBER (enter twice) _____

* Visit Number: V059

* TIME BEGAN				
HOUR		MINUTES		AM/PM

* DATE OF VISIT					
MONTH		DAY		YEAR	

* Date of Last Visit [in (Month, Year)] ___ / ___

* Date of birth ___ / ___ / _____ (8 Characters)

* **Q1.** Let's start with some medical conditions. Since your last visit [in (MONTH, YEAR)], were you diagnosed with ANY form of cancer? We are interested in all cancers, such as Kaposi's sarcoma, non-Hodgkin's lymphoma, anal, lung, prostate cancers, primary brain lymphoma, Hodgkin's disease, and Castleman disease.

- NO [GO TO Q2]
- YES [GO TO Q1.A1]
- REF [GO TO Q2]

Q1.A. IF YES: Where in the body was the cancer (Castleman's disease) and what kind of cancer did they say it was?

	1. 1 st Cancer	2. 2 nd Cancer
Cancer Code: (See MACS cancer codes)	___ . ___	___ . ___
Type of Cancer:		
Site of Cancer:		

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	1. 1st Cancer	2. 2nd Cancer
Medical Release Obtained:	<input type="checkbox"/> REF <input type="checkbox"/> YES	<input type="checkbox"/> REF <input type="checkbox"/> YES
Q1.B. In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?	1. 1st Cancer	2. 2nd Cancer
	_____ / _____ Month Year	_____ / _____ Month Year

Q1.C1. What was the name and address of the physician who diagnosed the first cancer?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: _____ / _____ / _____
Month Day Year

Q1.C2. What was the name and address of the physician who diagnosed the second cancer (if different from the first)?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: _____ / _____ / _____
Month Day Year

*** Q2.** 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 [GO TO Q3]

YES [GO TO Q2.A] →

REF [GO TO Q3]

Medical Release Obtained? REF YES

Q2.A. IF YES: What was the diagnosis?

	1. 1 st Diagnosis	2. 2 nd Diagnosis
What was the diagnosis?		
Description of AIDS diagnosis:		

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Code:	_ _ . _ _ _	_ _ . _ _ _
Q2.B. In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?	_ _ / _ _ _ _ Month Year	_ _ / _ _ _ _ Month Year
	<i>If Q2 YES, then Q2.B must be entered</i>	

Q3. Since your last visit [in (MONTH, YEAR)], were you diagnosed with pneumonia?

- NO [GO TO Q4]
 YES [GO TO Q3.A]
 REF [GO TO Q4]

→ **Medical Release Obtained?** REF YES

* **Q3.A.** In what month and year since your last visit [in (MONTH, YEAR)] was it first diagnosed?

_ _ / _ _ _ _
Month Year

Q3.B. What was the name and address of the physician who diagnosed the condition?

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: _ _ / _ _ / _ _ _ _
Month Day Year

* **Q4.A.** Since your last visit [in (MONTH, YEAR)], did you have a skin or blood test for TB, sometimes called a PPD?

PPD is the skin test and Quantiferon is the blood test

- NO [GO TO Q5] YES REF [GO TO Q5]

Q4.B. IF YES: When was your last test? _ _ / _ _ _ _

Q4.C. Was it positive? NO YES REF

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* **Q5.** Since your last visit [in (MONTH, YEAR)] have you had an active TB infection?

- NO
- YES
- REF

Medical Release Obtained? REF YES

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____/____/____
Month Day Year

* **Q6.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 [GO TO Q7]
- YES [GO TO Q6.A1]
- REF [GO TO Q7]

Medical Release Obtained? REF YES

Q6.A1. How many separate times were you a patient in a hospital since your last visit [in (Month, Year)]?

Q6.B. Tell me about (that hospitalization/outpatient procedure/each of those times) starting with the most recent hospitalization/outpatient procedure.

Q6.B1a. On what date did you last go into the hospital? ____/____/____
Month Day Year

Q6.B1b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

Q6.B1c. 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

Diagnosis: _____ ICD9: _____.____.

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

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2nd Diagnosis : _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: _____

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

Name of Hospital/clinic or doctor: _____
ADDRESS: _____
CITY: _____ - STATE _____ DATE: _____ / _____ / _____ Month Day Year

Q6.B2a. For your second most recent time to the hospital, on what date did you go into the hospital?

____ / ____ / ____
Month Day Year

Q6.B2b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

Q6.B2c. 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**

Diagnosis: _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: _____

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

Name of Hospital/clinic or doctor: _____
ADDRESS: _____
CITY: _____ - STATE _____ DATE: _____ / _____ / _____ Month Day Year

Q6.B3a. For your third most recent time to the hospital, on what date did you go into the hospital?

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____/____/____
Month Day Year

Q6.B3b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

Q6.B3c. 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**

Diagnosis: _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: _____

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____/____/____
Month Day Year

Q6.B4a. For your fourth most recent time to the hospital, on what date did you go into the hospital?

____/____/____
Month Day Year

Q6.B4b. How many nights did you spend in the hospital at that time? IF OUTPATIENT: FILL IN ZERO.

Q6.B4c. 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**

Diagnosis: _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

2nd Diagnosis : _____ ICD9: _____

CIRCLE ONE: V E P NA (no prefix for all other diagnoses)

OR Procedure: _____ ICD9: _____

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____ / ____ / ____
Month Day Year

Q7. Since your last visit [in (MONTH, YEAR)], have you consulted a mental health professional or been hospitalized or prescribed medications for treatment of depression?

- NO [GO TO Q8] DON'T KNOW [GO TO Q8]
 YES REF [GO TO Q8]

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

____ / ____
Month Year

Q8. 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 REF

[IF YES, RECORD DIAGNOSES IN Q10.CCi (Nervous System)]

* **Q9.A1.** 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.)

This does not include any PAP smears performed as part of the MACS Anal Health Study.

- NO [GO TO Q9.B] DON'T KNOW [GO TO Q9.B]
 YES [GO TO Q9.A2] REF [GO TO Q9.B]

Q9.A2. In what month and year did you have a pap smear performed?

____ / ____
Month Year

Q9.A3. Were the results abnormal?

- NO [GO TO Q9.B]
 YES
 DON'T KNOW
 REF [GO TO Q9.B]

Medical Release Obtained? REF YES

Q9.A4. Name of the doctor who performed the pap smear and where it was performed.

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Q9.B. Since your last visit [in (MONTH, YEAR)], has a doctor or medical practitioner inserted a tube-shaped

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____ / ____ / ____
Month Day Year

device or scope in your anus or rectum to look for hemorrhoids, fissures, infections and some cancers?

- NO
- YES
- DON'T KNOW
- REF

(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.")

Q9.C1. Since your last visit [in (MONTH, YEAR)], did you experience anal bleeding at any time?

- NO [GO TO [Q9.D](#)]
- YES [IF YES, GO TO [Q9.C2](#)]

Q9.C2. Since your last visit [in (MONTH, YEAR)], have you experienced any pain with the anal bleeding?

- NO [GO TO [Q9.C4](#)]
- YES [GO TO [Q9.C3](#)]
- REF [GO TO [Q9.C4](#)]

Q9.C3. Since your last visit [in (MONTH, YEAR)], how often have you experienced pain with the anal bleeding?

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

Q9.C4. Since your last visit [in (MONTH, YEAR)], has the bleeding occurred in any of the following situations? [READ EACH ITEM]

Q9.C4a. After or during anal receptive intercourse NO YES REF

Q9.C4b. After or during a bowel movement NO YES REF

Q9.C4c. Other times not associated with intercourse or bowel movements

- NO [GO TO [Q9.D1](#)]
- YES [GO TO [Q9.C5](#)]
- REF [GO TO [Q9.D1](#)]

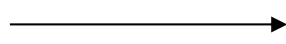
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Q9.C5. With respect to the *other times* (that you have had anal bleeding), how often have you experienced bleeding since your last visit [**in (MONTH, YEAR)**]?

- Daily Monthly
 Weekly Less than monthly

* **Q9.D1.** Since your last 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. READ: This includes any biopsies you have had as part of the MACS Anal Health Study.

- NO [GO TO [Q9.10A](#)]
 YES [GO TO [Q9.D2](#)]
 REF [GO TO [Q9.10A](#)]



Medical Release Obtained? <input type="checkbox"/> REF <input type="checkbox"/> YES

Q9.D2. How many times have you had a biopsy since your last visit [**in (MONTH, YEAR)**]?

Q9.D3. For each biopsy, please tell me (See Appendix 2 & 3 in the Medical History guidelines)

BIOPSY	1)	2)	3)
Q9.D3a. Where in your body?	Site Code: ___ ___ Specify: _____	Site Code: ___ ___ Specify: _____	Site Code: ___ ___ Specify: _____
Q9.D3b. What did they say the diagnosis or result of the biopsy was?	DX Code: ___ ___ Specify: _____	DX Code: ___ ___ Specify: _____	DX Code: ___ ___ Specify: _____
Q9.D3c. Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ____/____/____	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ____/____/____	Name of doctor: _____ Name of hospital/center/clinic: _____ _____ CITY _____ State _____ Date ____/____/____

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Q10. I am now going to ask you about other **NEW** conditions, ailments or disorders. Were you diagnosed with any of the following since your last visit [**in (MONTH, YEAR)**]?

- | | | | | | | |
|---|--------------------------|----|--------------------------|-----|--------------------------|-----|
| A. Thrush (yeast in your mouth) | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| B. Sinusitis, a sinus infection that requires antibiotics | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| C. Bronchitis | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| D. Erectile dysfunction (erectile problems) | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| E. High blood pressure or hypertension | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| F. High cholesterol, high triglycerides, high lipids or too much fat in your blood | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| G. High blood sugar or diabetes | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| H. Arthritis | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |

IF YES: Was it:

- | | | | | | | | | |
|----------------------------------|--------------------------|----|--------------------------|-----|--------------------------|----|--------------------------|-----|
| ▪ Rheumatoid | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | DK | <input type="checkbox"/> | REF |
| ▪ Osteoarthritis or Degenerative | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | DK | <input type="checkbox"/> | REF |
| ▪ Other | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | DK | <input type="checkbox"/> | REF |



Specify Other:

Obtain a medical release for each item below with a “YES” response for items Q10.I - Q10.Q. Fill out the medical provider boxes on page 11.

- | | | | | | | |
|---|--------------------------|----|--------------------------|-----|--------------------------|-----|
| *I. Angina or chest pain caused by your heart | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *J. Heart attack or myocardial infarction (MI) | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *K. Congestive heart failure or CHF | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *L. Stroke or Cerebrovascular accident (CVA) | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *M. Mini-strokes or transient ischemic attacks (TIA) | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *N. Too fast, too slow, or irregular heart beat | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *O. Any blood vessels (arteries) that were blocked or closed | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |
| *P. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas | <input type="checkbox"/> | NO | <input type="checkbox"/> | YES | <input type="checkbox"/> | REF |



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*Q. A blood clot in your legs

NO YES REF

*R. Kidney disease/Renal failure

NO YES REF

What was the name and address of the physician who diagnosed the condition(s)? If more than one diagnosis, ask if same or different doctors.

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____/____/____
Month Day Year

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: ____/____/____
Month Day Year

Administration: These are baseline questions and will be administered one time to all participants and followed up with since your last visit question every visit going forward.

Introduction:

We are now going to ask you about heart problems that may have been diagnosed prior to age 55 among the men and prior to age 65 among the women in your immediate family. Immediate family comprises your biological father, mother, brothers and sisters.

Mark here for those participants who do not know them because they are adopted.

Interviewer note: Questions apply to all living and deceased immediate family members. If a participant's family member was diagnosed with a heart attack and later died of a heart attack before age 55 if male or age 65 if female, fill in yes for both questions for this same family member. Similarly, if diagnosed with a heart attack and had surgery, fill in yes for both questions. All events have to occur prior to age 55 for men and age 65 for women. If the participant is not sure, mark DK. If he is able to contact you after the interview with a definite answer, update the CADI with this new information

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Q10.fam

1. Has a male member of your immediate family

a) ever been diagnosed with a Heart Attack before age 55?

NO

YES

DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

REF

b) ever died from a Heart Attack before age 55?

NO

YES

DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

REF

2. Has a female member of your immediate family

a) ever been diagnosed with a Heart Attack before age 65?

NO

YES

DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

REF

b) ever died from a Heart Attack before age 65?

NO

YES

DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

REF

3. Has a male member of your immediate family

a) ever had heart bypass surgery before age of 55?

NO

YES

DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)

REF

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b) ever had an angioplasty with or without a stent before the age of 55?

- NO
 YES
 DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
 REF

4. Has a female member of your immediate family

a) ever had heart bypass surgery before age of 65?

- NO
 YES
 DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
 REF

b) ever had an angioplasty with or without a stent before the age of 65?

- NO
 YES
 DK (mark don't know if no longer in contact with the family or is unsure of the age when event occurred)
 REF

Q10. (cont.) Going back to other **NEW** conditions, ailments or disorders. Were you diagnosed with any of the following since your last visit [**in (MONTH, YEAR)**]?

S. Elevated Liver Enzyme NO YES REF

T1. Are you currently enrolled in the Bone Strength Sub Study?

NO [**GO TO Q10.T2**] YES REF [**GO TO Q10.T2**]

T1a. Have you had any falls since your last visit?

NO YES REF

IF YES:

T1b. Have you previously reported this fall to the clinic?

NO YES REF DK

IF NO OR DK:

Administer the Fall Reporting Tool: http://www.research.net/S/Boss_Fall_Reporting_Tool

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T2. Broken or fractured bones

NO YES REF

[IF NO OR REF, GO TO [Q10.CCa](#)]

T2a. What was fractured?

[See Appendix Q9A in
Guidelines for ICD9 codes]

T3. Did that fracture occur.... (Select one)

- Without any trauma or fall (i.e., without any external force,: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- Because of a harder fall (example, falling down steps)
- From a car accident or other severe external force
- Don't know

Q10.CC. Since your last visit [in (MONTH, YEAR)], have you seen a health care provider, or have gone to a clinic, urgent care facility, or emergency room or any OTHER NEW conditions or problems in the following areas?

Q10.CCa. Eyes

NO YES REF

[IF NO OR REF, GO TO [Q10.CCb](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Q10.CCb. Ears, Nose, Throat, Mouth and Sinuses

NO YES REF

[IF NO OR REF, GO TO [Q10.CCc](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Q10.CCc. Heart and Blood Vessels

NO YES REF

[IF NO OR REF, GO TO [Q10.CCd](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

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Get Medical Release if answer to **heart condition** is yes.

Q10.CCd. Lungs and Bronchial Tubes

NO YES REF

[IF NO OR REF, GO TO [Q10.CCe](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Q10.CCe. Stomach, Intestines, or Liver Disease

NO YES REF

[IF NO OR REF, GO TO [Q10.CCf](#)]

Get Medical Release if answer to **liver disease** is yes.

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Liver Diagnosis:

NO YES REF

Name of Hospital/clinic or doctor:

ADDRESS:

CITY: _____ **- STATE** _____ **DATE:** ____/____/____

Q10.CCf. Bones, Joints or Muscles

NO YES REF

[IF NO OR REF, GO TO [Q10.CCg](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Osteoporosis, Avascular Necrosis or Osteonecrosis:

NO YES REF

Get Medical Release if osteoporosis, avascular necrosis or osteonecrosis

Q10.CCg. Genital, Urinary and Rectal

NO YES REF

[IF NO OR REF, GO TO [Q10.CCh](#)]

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IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis?

Q10.CCh. Skin

NO YES REF

[IF NO OR REF, GO TO [Q10.CCi](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis?

Q10.CCi. Nervous system

NO YES REF

[IF NO OR REF, GO TO [Q10.CCj](#)]

Get Medical Release if answer to **nervous system** is YES.

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis?

Name of Hospital/clinic or doctor:

ADDRESS:

CITY: _____ **- STATE** _____ **DATE:** ____ / ____ / _____

Q10.CCj. Treatment of depression, anxiety,
or other health problems?

NO YES REF

[IF NO OR REF, GO TO [Q10.CCk](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis?

Q10.CCk. Hormones or Endocrine system

NO YES REF

[IF NO OR REF, GO TO [Q10.CCb](#)]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis?

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Q10.CCI. Other

NO YES REF

[IF NO OR REF, GO TO **Q11.A**]

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

Q11.A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, since your last visit [in **MONTH, YEAR**)]?

Q11.A1. Facial herpes, cold sores, or fever blisters

NO YES REF

Q11.A2. Sores in genital region

NO YES REF

Q11.A3. Sores in the anal or rectal areas

NO YES REF

Q11.A4. Sores elsewhere on your body

NO YES REF

[IF NO TO ABOVE, GO TO **Q12**]

Q11.B. Did the first attack of herpes you ever had occur since your last visit [in (**MONTH, YEAR**)]?

NO YES REF

Q11.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?

NO YES REF

Q12. Have you had any of the following diseases or conditions since your last visit [in (**MONTH, YEAR**)]? How about (**EACH**)?

Q12.A1. Syphilis

NO YES REF

[IF NO OR REF, GO TO **Q12.B**. IF YES, GO TO **Q12.A2**]

Q12.A2. Was this a new infection or was it a continuation or relapse of a previous infection?

New infection

Continued or relapse

Q12.B. Any form of gonorrhea

NO YES REF

[IF NO OR REF, GO TO **Q12.F**. IF YES, GO TO **Q12.C**]

Q12.C. Urethral gonorrhea (clap or drip of the urinary passage)

NO YES REF

Q12.D. Oral gonorrhea (of the mouth or throat)

NO YES REF

Q12.E. Rectal gonorrhea (of the rectum)

NO YES REF

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Q12.F. Non-specific or nongonococcal urethritis or chlamydia (that is, a discharge from the penis that's not caused by gonorrhea) NO YES REF

Q12.G1. Genital warts (condylomata acuminata) NO YES REF

[IF NO OR REF, GO TO [Q12.H1](#). IF YES, GO TO [Q12.G2](#)]

Q12.G2. Was this a new infection or was it a continuation or relapse of a previous infection?

New infection Continued or relapse

Q12.H1. Anal warts (condylomata acuminata) NO YES REF

[IF NO OR REF, GO TO [Q13.A1](#). IF YES, GO TO [Q12.H2](#)]

Q12.H2. Was this a new infection or was it a continuation or relapse of a previous infection?

New infection Continued or relapse

Q13.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, AND e.	(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?
1) Persistent dizziness for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
7) Diarrhea for at least 3 consecutive days	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
8) Drenching sweats at night on at least 3 occasions	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
9) Nausea, vomiting	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES

Visit 59 CADI Form

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	(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?
10) Abdominal pain, bloating, cramps	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
11) Ascites (fluid buildup in the stomach or abdomen)	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
13) An unintentional weight loss of at least 10 pounds unrelated to dieting	<input type="checkbox"/> NO <input type="checkbox"/> YES		<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
14) Muscle pain or weakness	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
15) Joint pain	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
16) Vivid nightmares or dreams	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
17) Insomnia or problems sleeping	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES
18) Persistent dry mouth	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK	<input type="checkbox"/> NO <input type="checkbox"/> YES

Q13.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	DK
1. Pain, aching, or burning in your feet or legs?	<input type="checkbox"/>	<input type="checkbox"/>	Right _____ (0-10) Left _____ (0-10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Pins and needles in your feet or legs?	<input type="checkbox"/>	<input type="checkbox"/>	Right _____ (0-10) Left _____ (0-10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Numbness (lack of feeling) in your feet or legs?	<input type="checkbox"/>	<input type="checkbox"/>	Right _____ (0-10) Left _____ (0-10)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Moving on to medications and vaccines for HIV.

Visit 59 CADI Form

* **Q14.1.** Since your last visit, [in (MONTH, YEAR)], have you been given a vaccine against HIV in a research trial?

NO YES REF

[IF NO, GO TO **Q15**. IF YES, GO TO **Q14.2** (MUST BE FILLED OUT) AND THEN GO TO **Q14.3**]

[OPTIONAL – DOESN'T HAVE TO BE FILLED OUT]

Q14.2. What is the name of the trial?

See <http://www.aidsinfo.nih.gov/clinical-trials/>.
If not identifiable based on information from participant,
obtain a medical release to get name and NCT number from his doctor.

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

CITY: _____ STATE _____ DATE: _____ / _____ / _____
Month Day Year

Q14.3. MACS CODE _____

[IF NO MACS CODE, CONTACT CAMACS.
SEE MACS FORUM - [VACCINE AND CLINICAL RESEARCH TRIALS](#)]

* **Q15.** 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 [GO TO **Q15.A1**] YES [GO TO **Q15.A1**] REF [GO TO **Q15.A1**]

Q15.A. IF NO: Why did you decide not to take HIV-related medications?

- | | |
|--|---|
| 1. Not infected with HIV [IF YES, GO TO Q16] | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 2. Doctor said was not necessary | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 3. Not sick | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 4. Too expensive | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 5. Don't think they work or will help | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 6. Possible side effects | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 7. 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) | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |
| 8. Other reason | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF |

Visit 59 CADI Form

Q15.A1. 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
 YES
 DON'T KNOW
 REF

→ **SKIP TO Q15.B(1) IF ON HIV MEDS SINCE LAST VISIT
SKIP TO Q16 IF NOT ON HIV MEDS SINCE LAST VISIT**

Q15.A2. Has your treatment (drugs) been changed as a result of that test?

- NO
 YES
 DON'T KNOW
 REF

*** Q15.B1** Since your last visit [in (MONTH, YEAR)], have you taken any medication or drug on this list?

[Show the picture list in the current March/April 2013 Positively Aware Magazine]

- NO
 YES [GO TO Q15.B3]
 REF

Q15.B2. Please name those drugs that you have taken or show me which ones.

**Fill out a separate Drug Form 1 / Adherence form for each reported drug taken since last visit.
NOTE- USE THE CADI COMPATIBLE PAPER FORMS ONLY. DO NOT USE THE SCAN FORM.**

Administer DRUG and ADHERENCE Forms for Abbreviated Interviews.

[CONTINUE ADHERENCE QUESTIONS FOR ALL CURRENT DRUGS.]

I would like to ask some Adherence questions about the anti-HIV medications you are currently taking.

Q2. When was the last time you skipped any of your medications?

- Never skip medications [GO TO Q4]
 Within the past week
 1-2 weeks ago
 3-4 weeks ago
 1-3 months ago
 More than 3 months ago

Visit 59 CADI Form

Q3. People miss taking their medications for various reasons. Here is a list of possible reasons. How often have you missed taking your current medications because you :

Q3.	Never	Rarely	Sometimes	Often	Refuse
a. Were away from home?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Were busy with other things?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Simply forgot?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Had too many pills to take?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Wanted to avoid side effects?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Did not want others to notice you taking medications?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Had a change in daily routine? (e.g., vacation, holiday, non-work day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Felt like the drug was toxic or harmful?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Fell asleep or slept through dose time	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Felt sick or ill	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Felt depressed or overwhelmed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Had problems taking the pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Ran out of pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Don't want to take pills?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Have special instructions that conflict?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
p. Other reason	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify other reason:					

Q4. Most anti-HIV medications need to be taken on a schedule, such as "2 times a day" or "every 8 hours". How closely did you follow your specific schedule over the last four days?

- | | |
|---|---|
| <input type="checkbox"/> Never | <input type="checkbox"/> Most of the time |
| <input type="checkbox"/> Some of the time | <input type="checkbox"/> All of the time |
| <input type="checkbox"/> About half of the time | <input type="checkbox"/> REF |

Visit 59 CADI Form

Q5a. Do any of your anti-HIV medications have special instructions such as "take with food" or "take on an empty stomach" or "take with plenty of fluids"?

NO [*GO TO Q6*] YES REF

Q5b. How often did you follow those special instructions over the last four days?

Never Most of the time
 Some of the time All of the time
 About half of the time REF

Q5c. Do any of these special instructions conflict? NO YES REF

Q6. How do you remember to take your medications?

Q6	NO	YES	REF
a. Calendar/diary	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Pill box	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Alarm?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Friends/family member	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Memory only	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Other specify:			

Q15.B3. 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 [*GO TO Q15.C1*] YES REF [*GO TO Q15.C1*]

IF YES: How many times did this occur? ____

Did your physician prescribe or agree to any of these? NO YES REF

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

* **Q15.C1.** 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 [*GO TO Q15.C3*] YES REF [*GO TO Q15.C3*]

Visit 59 CADI Form

Q15.C2. Please name those drugs that you have taken.

Name: _____

Code: _____

Name: _____

Code: _____

Name: _____

Code: _____

END ABBREVIATED INTERVIEW.

Q15.C3. In the past year, have you participated in any other research studies involving treatment or prevention of HIV or its complications?

NO YES REF

Q15.C4. What is the name of the trial?

See <http://www.aidsinfo.nih.gov/clinical-trials/>. If not identifiable based on information from participant, obtain a medical release to get name and NCT number from his doctor.

Q15.C5. MACS CODE _____

If no MACS code, contact CAMACS. See MACS forum - [Vaccine and clinical research trials](#)

Q16. 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)]

You are being asked about your use of the following types of medications because of their potential effects on your overall health, including your long term risks for development of illnesses such as diabetes, heart disease, and osteoporosis, as well as their potential overall effects on the health of your muscles, liver, kidneys, and your sexual functioning. Similarly, the health effects of normal aging may be impacted by the use of these medications.

Visit 59 CADI Form

Testosterone:

Q16.1A. Since your last visit, have you used testosterone in any of the following preparations, including *Androgel, Testim, Fortesta, Androderm (patch), Testosterone injection (Delatestryl)*?

NO YES DON'T KNOW REF

[IF NO, DON'T KNOW OR REFUSED, GO TO **Q16.12A**]

If YES:

Q16.1B. Was the testosterone prescribed by a health care provider?

NO YES REF

Q16.1C. What were the reasons for using testosterone? Was it because of [Read each item]

- | | | | |
|---|-----------------------------|------------------------------|------------------------------|
| 1) Low testosterone level | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 2) Wasting or unintentional weight loss | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 3) To build muscle mass | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 4) Erectile Dysfunction | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 5) Low sexual desire | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 6) Fatigue | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 7) Anemia (low red blood cells) | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 8) To feel stronger or more energetic | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 9) Improve athletic performance | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 10) Also taking Megace (megesterol) | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 11) Other | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |

If yes: specify _____

Q16.1D. How was it administered? Was it by [Read each item]

- 1) Injection NO YES REF

IF YES:

Have you gotten an injection in the last 2 weeks? NO YES REF

- 2) Gel or patch NO YES REF

IF YES:

Have you applied it in the last 24 hours? NO YES REF

- 3) Under skin pellet (Testopel) NO YES REF

IF YES:

Have you had a pellet placed in the last 6 months? NO YES REF

Visit 59 CADI Form

Anabolic Steroids:

Q16.2A. Since your last visit [in (MONTH, YEAR)], have you taken any anabolic steroids, such as *Anadrol-50*, *Winstrol*, *Oxandrin*?

NO [GO TO [Q16.3A](#)]

REF [GO TO [Q16.3A](#)]

YES

DON'T KNOW [GO TO [Q16.3A](#)]

OTHER

Specify: _____

If YES or OTHER:

Q16.1B. What were the reasons for taking this/these steroid(s)? [Read each item]

1) Wasting or unintentional weight loss

NO YES REF

2) To build muscle mass

NO YES REF

3) To feel stronger or more energetic

NO YES REF

4) Improve athletic performance

NO YES REF

5) Other

NO YES REF

If yes: specify: _____

Q16.2C. Have you taken/used the anabolic steroids in the past 5 days?

NO YES

Glucocorticoids (corticosteroids):

Q16.3A. Thinking about medications taken in your past, have you EVER taken any steroids by mouth called glucocorticoids or corticosteroids, such as *prednisone*, *dexamethasone (Decadron)*, *hydrocortisone*, *prednisolone (Prelone)*, *methylprednisolone (Medrol)*?

NO [GO TO [Q16.3F](#)]

REF [GO TO [Q16.3F](#)]

YES

DON'T KNOW [GO TO [Q16.3F](#)]

If YES:

Q16.3B. Approximately, how old were you when you last took any? _____

Q16.3C. Have you ever taken any of these steroid pills for a period of greater than 3 months?

NO YES REF

Visit 59 CADI Form

Q16.3D. Now thinking about since your last visit only, how many days in total have you taken glucocorticoid or corticosteroid pills? *(if none, fill in 0)*

[IF NONE (Days = 0), GO TO [Q13.3F](#)]

_____ (up to 3 characters, must be numbers entered)

Q16.3E. What were the reasons for taking this/these steroid(s) since your last visit? *(mark all that apply)*

- | | | | |
|--------------------------|-----------------------------|------------------------------|------------------------------|
| 1) Adrenal insufficiency | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 2) Lung condition | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 3) Joint condition | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 4) Back condition | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 5) Skin condition | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| 6) Other | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |

Specify: _____

Q16.3F. Since your last visit [in (MONTH, YEAR)], have you had an injection of this/these steroid(s) into your skin or joints, back, muscle?

NO YES REF

[IF NO GLUCO MEDS SINCE LAST VISIT, GO TO [Q16.4a](#)]

Q16.3G. Have you taken/used the glucocorticoid(s) or corticosteroid(s) by any means in the past 5 days?

NO YES REF

Q16.4A. Since your last visit [in (MONTH, YEAR)], have you taken any inhaled steroids?

NO YES REF

[IF NO, GO TO [Q16.5A](#)]

Note to interviewer: If the participant reported an inhaled medication, but is not sure whether it was a steroid, read aloud the names of the drugs listed below.

If YES:

Q16.4B. Which one(s):

Beclomethasone	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
QVAR	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Budesonide	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Pulmicort	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Ciclesonide	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Alvesco	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Flunisolide	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF

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AeroBid	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Fluticasone	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Flovent	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Mometasone	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Asmanex Twisthaler	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Triamcinolone	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Azmacort	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Budesonide and formoterol	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Symbicort	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Fluticasone and salmeterol	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Advair	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Mometasone and formoterol	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
Dulera	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF

Q16.4C. Have you taken/used the inhaled steroid(s) in the past 5 days?

YES NO REF

Q16.5A. Since your last visit [in (MONTH, YEAR)], have you taken thyroid hormones, such as *Synthroid*, *Levoxyl*, *levothyroxine*, or *Cytomel*?

- YES REF
 NO [GO TO [Q16.6A](#)] DON'T KNOW [GO TO [Q16.6A](#)]
 OTHER

Specify: _____

Q16.5B. Have you taken/used thyroid hormone(s) in the past 5 days?

NO YES REF

Q16. Continued	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 and what did you take this drug for?	c. Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?
6. Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
7. Tranquilizers or sleeping pills	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
8. Antidepressants or mood elevators	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES

Visit 59 CADI Form

Q16. Continued	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 and what did you take this drug for?	c. Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?
9. Acyclovir, famciclovir or valacyclovir for herpes (zovirax, famvir, valtres) IF YES, did you take it: Everyday <input type="checkbox"/> NO <input type="checkbox"/> YES Only when you had active lesions or outbreak? <input type="checkbox"/> NO <input type="checkbox"/> YES	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
10. Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
11. Aspirin taken three days or more on a weekly basis	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
12. Medications to lower cholesterol, triglycerides, lipids or blood fat _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES
13. Medications to treat hypertension _____ _____ _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____ _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input style="color: red; font-weight: bold; font-size: small; margin-bottom: 5px; display: block; margin-left: auto; margin-right: auto;"/> HY45 <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES
14. Medications to treat diabetes	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
_____	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES

Visit 59 CADI Form

Q16. Continued	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 and what did you take this drug for?	c. Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?
-----	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
-----	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
15. Medications to treat hepatitis			
-----	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
-----	<input type="checkbox"/> NO <input type="checkbox"/> YES	_____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES

Visit 59 CADI Form

a) Have you (taken/used) Any other medications since your last visit [in (MONTH, YEAR)]?	b) When specified, what was the name of the (KIND OF DRUG) you took?	c) What did you take this drug for?	d) Have you taken/used any in the past 5 days?
16. Other a. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
b. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
c. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
d. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
e. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
f. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
g. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES

Visit 59 CADI Form

a) Have you (taken/used) Any other medications since your last visit [in (MONTH, YEAR)]?	b) When specified, what was the name of the (KIND OF DRUG) you took?	c) What did you take this drug for?	d) Have you taken/used any in the past 5 days?
h. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
i. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
j. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
k. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
l. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES
m. <input type="checkbox"/> NO <input type="checkbox"/> YES	Name and code of drug: _____ _____	Use of drug: _____ _____ _____	<input type="checkbox"/> NO <input type="checkbox"/> YES

Q17.A. Since your last visit [in (MONTH, YEAR)], have you received assistance from ADAP (AIDS Drug Assistance Program)?

NO YES REF

Visit 59 CADI Form

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

Q17.B. Since your last visit [in (MONTH, YEAR)], have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

NO [GO TO **Q17.C**]

YES - did you have: [GO TO **Q17.B1**]

REF

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, **TRICARE**, **CHAMPUS** or **CHAMP-VA** medical insurance for dependents of military personnel or survivors of disabled veterans. NO YES

7) Ryan White NO YES

8) Other NO YES

Specify Other:

Q17.C. Did you have insurance coverage that pays for any of your medications?

NO YES REF DON'T KNOW

[IF **Q17.C** AND **Q17.B** = NO, GO TO **Q19**. IF **Q17.C** OR **Q17.B** = YES, GO TO **Q18**]

Q18. Are you currently insured? NO YES REF

Q19. Did you have any type of dental insurance coverage at any time since your last visit [MONTH, YEAR]?

NO YES REF

Visit 59 CADI Form

Q20. Since your last visit [in (MONTH, YEAR)], have you gone to ANY of the following sources for your outpatient medical care? (**ASK FOR EACH ITEM**) (This does not include dental health care, mental health care, home health care, clinical trials or other research studies, including MACS.) [**SHOW CARD WITH EXAMPLES OF EACH CATEGORY.**]

Source for Medical Care	Have you used...	How many times?
1) HMO	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
3) Any other clinic	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
4) Emergency room	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
5) Other outpatient service	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
<i>Specify Other:</i>		

Q21.A. Since your last visit [in (MONTH, YEAR)], have you seen a dental health care provider, such as a dentist or dental hygienist?

NO YES REF

[IF NO OR REF, GO TO **Q21.C**. IF YES, GO TO **Q21.B**]

Q21.B. How many times? ___ ___

Q21.C. We are also interested in oral hygiene, which may affect the transmission of infections. How often do you usually brush your teeth?

- | | |
|---|--|
| <input type="checkbox"/> Don't brush at all | <input type="checkbox"/> 2 times per day |
| <input type="checkbox"/> Less than once a day | <input type="checkbox"/> 3 times or more per day |
| <input type="checkbox"/> 1 time per day | |

Q22.A. Was there a time since your last visit [in (MONTH, YEAR)] when you did not seek medical care, or dental care, or did not obtain prescription medications that you thought you needed?

NO YES REF

[IF NO OR REF, GO TO **Q23.A**. IF YES, GO TO **Q22.B**]

Visit 59 CADI Form

Q22.B. IF YES: Why did you not seek care or obtain prescription medications?
[READ EACH AND MARK ALL THAT APPLY]

Financial reasons: NO YES REF

Other non-financial reasons: NO YES REF

Specify Other: _____

Q23.A. Is there anything more that I haven't asked that you think we should know?

- NO, nothing more YES

THANK PARTICIPANT AND GO TO ITEM 24

Q23.B. Tell me about it. **RECORD FULLY IN R'S OWN WORDS**

TEXT BOX for THINGS TO KNOW:

Q24. Administration of Behavior Section “[If the participant does not complete the MWII (ACASI), administer the CADI paper version of the behavior section and scannable paper versions of the full QOL and S2/S3.]”

- CADI Interview
 MWII (ACASI)
 Participant Refused behavior section

Q25. Telephone interview? NO YES

Q26. Home visit? NO YES

Q27. Interview Method

- Interview conducted on a paper form then entered into CADI

Visit 59 CADI Form

Q27.a. Abbreviated interview? NO YES

Q28. DATE INTERVIEW WAS COMPLETED: ___ ___ / ___ ___ / ___ ___ ___ ___ (8 characters)

**IF BEHAVIOR SECTION IS ADMINISTERED BY FORM,
GO TO Q29 AND FILL IN TIME ENDED AFTER THE COMPLETION
OF THE PREP & THE BEHAVIOR SECTION.**

Time ended: Hours ___ ___

Minutes ___ ___

AM/PM ___

Interviewers name:

Last name _____

First Name _____

INTERVIEWER'S NUMBER ___ ___ ___

Choose clinic:

BA Moore Clinic

BA Whitman Walker

CH Howard Brown

CH Northwestern

CH CORE

PI

PI (Ohio)

LA Wilshire

LA LAGLC

LA Harbor

LA Satellite Clinic

Visit 59 CADI Form

Q30. In the past 2 years, have you used anti-HIV medications to try to prevent YOURSELF from getting infected either before being exposed to HIV or following a possible exposure to HIV; this is sometimes called PREP (for pre-exposure prophylaxis) or PEP (for post-exposure prophylaxis)?

- NO HIV infected (Not applicable)
 YES REF
 Don't remember

[IF NO OR DON'T KNOW OR IF NOT HIV INFECTED, THEN GO TO [Q31](#)]

1st Medication

Q30.a1. Which anti-HIV medications did you take?

- | | |
|--|---|
| <input type="checkbox"/> Truvada | <input type="checkbox"/> Norvir (Viramune) |
| <input type="checkbox"/> Emtriva (FTC) | <input type="checkbox"/> Prezista (darunavir) |
| <input type="checkbox"/> Viread (tenofovir) | <input type="checkbox"/> Reyataz (atazanavir) |
| <input type="checkbox"/> Atripla | <input type="checkbox"/> Sustiva (efavirenz) |
| <input type="checkbox"/> Epzicom | <input type="checkbox"/> Other prescribed |
| <input type="checkbox"/> Isentress (Raltegravir) | <input type="checkbox"/> Over-the-counter or herbal preps |

Q30.b1. In the last 6 months, did you use this drug when you knew or suspected you would be having sex, or after sex?

- NO YES REF

[IF NO OR REF, GO TO [Q30.d1](#)]

Q30.c1. If YES, when did you take (Insert Medication Name)

- | | | | | |
|---|-----------------------------|------------------------------|-------------------------------------|------------------------------|
| 1) Within 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |

Q30.d1. How often did you typically use this drug in the last 6 months?

Choose one:

- | | |
|--|---|
| <input type="checkbox"/> Daily or almost daily | <input type="checkbox"/> Only once or twice in the last 6 months |
| <input type="checkbox"/> Once or twice per week | <input type="checkbox"/> Used in the last 2 years but not last 6 months |
| <input type="checkbox"/> At least once per month, but less than weekly | <input type="checkbox"/> REF |

Visit 59 CADI Form

Q30.e1. How did you obtain this medication?

- | | | | |
|---|-----------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> It was prescribed by my doctor | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> As part of a clinical research study | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From a sexual partner | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From some other non-medical source | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> Are there other medications? | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |

[IF YES, GO TO 2ND MEDICATION. IF NO OR REF, GO TO [Q31](#)]

2nd Medication

Q30.a2. Which anti-HIV medications did you take?

- | | |
|--|---|
| <input type="checkbox"/> Truvada | <input type="checkbox"/> Norvir (Viramune) |
| <input type="checkbox"/> Emtriva (FTC) | <input type="checkbox"/> Prezista (darunavir) |
| <input type="checkbox"/> Viread (tenofovir) | <input type="checkbox"/> Reyataz (atazanavir) |
| <input type="checkbox"/> Atripla | <input type="checkbox"/> Sustiva (efavirenz) |
| <input type="checkbox"/> Epzicom | <input type="checkbox"/> Other prescribed |
| <input type="checkbox"/> Isentress (Raltegravir) | <input type="checkbox"/> Over-the-counter or herbal preps |

Q30.b2. In the last 6 months, did you use this drug when you knew or suspected you would be having sex, or after sex?

- NO YES REF

[IF NO OR REF, GO TO [Q30.d2](#)]

Q30.c2. If YES, when did you take (Insert Medication Name)

- | | | | | |
|---|-----------------------------|------------------------------|-------------------------------------|------------------------------|
| 1) Within 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |

Q30.d2. How often did you typically use this drug in the last 6 months?

Choose one:

- | | |
|--|---|
| <input type="checkbox"/> Daily or almost daily | <input type="checkbox"/> Only once or twice in the last 6 months |
| <input type="checkbox"/> Once or twice per week | <input type="checkbox"/> Used in the last 2 years but not last 6 months |
| <input type="checkbox"/> At least once per month, but less than weekly | <input type="checkbox"/> REF |

Visit 59 CADI Form

Q30.e2. How did you obtain this medication?

- | | | | |
|---|-----------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> It was prescribed by my doctor | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> As part of a clinical research study | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From a sexual partner | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From some other non-medical source | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |

Are there other medications? NO YES REF

[IF YES, GO TO 3rd MEDICATION. IF NO OR REFUSE GO TO [Q31](#)]

3rd Medication

Q30.a3. Which anti-HIV medications did you take?

- | | |
|--|---|
| <input type="checkbox"/> Truvada | <input type="checkbox"/> Norvir (Viramune) |
| <input type="checkbox"/> Emtriva (FTC) | <input type="checkbox"/> Prezista (darunavir) |
| <input type="checkbox"/> Viread (tenofovir) | <input type="checkbox"/> Reyataz (atazanavir) |
| <input type="checkbox"/> Atripla | <input type="checkbox"/> Sustiva (efavirenz) |
| <input type="checkbox"/> Epzicom | <input type="checkbox"/> Other prescribed |
| <input type="checkbox"/> Isentress (Raltegravir) | <input type="checkbox"/> Over-the-counter or herbal preps |

Q30.b3. In the last 6 months, did you use this drug when you knew or suspected you would be having sex, or after sex?

- NO YES REF

[IF NO OR REFUSE, GO TO [Q30.d3](#)]

Q30.c3. If YES, when did you take (Insert Medication Name)

- | | | | | |
|---|-----------------------------|------------------------------|-------------------------------------|------------------------------|
| 1) Within 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DON'T KNOW | <input type="checkbox"/> REF |

Q30.d3. How often did you typically use this drug in the last 6 months?

Choose one:

- | | |
|--|---|
| <input type="checkbox"/> Daily or almost daily | <input type="checkbox"/> Only once or twice in the last 6 months |
| <input type="checkbox"/> Once or twice per week | <input type="checkbox"/> Used in the last 2 years but not last 6 months |
| <input type="checkbox"/> At least once per month, but less than weekly | <input type="checkbox"/> REF |

Visit 59 CADI Form

Q30.e3. How did you obtain this medication?

- | | | | |
|---|-----------------------------|------------------------------|------------------------------|
| <input type="checkbox"/> It was prescribed by my doctor | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> As part of a clinical research study | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From a sexual partner | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| <input type="checkbox"/> From some other non-medical source | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |

Q31.a. At present, which of the following categories describes your annual individual gross income before taxes?

- | | |
|---|--|
| <input type="checkbox"/> Less than \$10,000 | <input type="checkbox"/> \$50,000-\$59,999 |
| <input type="checkbox"/> \$10,000-\$19,999 | <input type="checkbox"/> \$60,000-\$99,999 |
| <input type="checkbox"/> \$20,000-\$29,999 | <input type="checkbox"/> \$100,000-149,999 |
| <input type="checkbox"/> \$30,000-\$39,999 | <input type="checkbox"/> \$150,000 or more |
| <input type="checkbox"/> \$40,000-\$49,999 | <input type="checkbox"/> Do not wish to answer |

Q31.b. What was the highest grade or level of regular school or college that you finished and got credit for? Choose the answer that best describes the last year of school you completed.

- | | |
|---|--|
| <input type="checkbox"/> 8th grade (or less) | <input type="checkbox"/> Four years of college and got a degree |
| <input type="checkbox"/> 9th, 10th, or 11th grade | <input type="checkbox"/> Some graduate school |
| <input type="checkbox"/> 12th grade (high school graduate or a GED) | <input type="checkbox"/> A graduate program and got a post-graduate degree |
| <input type="checkbox"/> At least one year of college but no degree | |

Q31.c What is your current employment status? (*Please select all that apply to you.*)

- Working full-time (35 hours or more per week)
- Working part-time (less than 35 hours per week)
- Unemployed but seeking work
- Unemployed, not seeking work
- Student (either full-time or part-time)
- Retired
- Disability

Q31.d Are you self-employed? NO YES REF

Q31.e. Are you experiencing major financial difficulty meeting your basic expenses?

- NO YES REF

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Q31.f. Is the difficulty less, the same, or greater than at your last visit in [5, 2010]?

- Less Greater
 Same REF

Q32. Since your last visit in [5,2010], has your employment status changed for any reason related to HIV disease?

- NO YES REF

[IF YES, GO TO [Q32.A](#). IF NO, GO TO [Q33.A1](#)]

Q32.a. What were the reasons? (Please select all that apply to you.)

- Became too sick to work
 Early retirement
 Changed job as a personal decision
 Other

Specify: _____

The following is a series of questions about specific behaviors, including cigarette smoking, alcohol use, sexual activities, and recreational drug use.

Q33.A1. Have you ever smoked cigarettes?

- NO [[GO TO Q33.d](#)] YES [[GO TO Q33.A2](#)]

Q33.A2. Thinking about the entire time you have smoked cigarettes, what percentage of that time did you smoke menthol cigarettes?

- 100–75% of the time
 Less than 75% but greater than 25% of the time
 Less than 25% of the time

Q33.B. Do you smoke cigarettes now (as of 1 month ago)?

- NO [[GO TO Q33.d](#)]
 YES [[GO TO Q33.c](#)]
 Occasionally (less than one cigarette per day) [[GO TO Q33.d](#)]

Visit 59 CADI Form

Q33.C. How many packs do you usually smoke per day?

- Less than ½ pack
- At least ½ pack; but less than 1 pack per day
- At least 1 but less than 2 packs
- 2 or more packs per day

Q33.D. Since your last visit [in MONTH, YEAR], how many months have you lived in a household with at least one cigarette smoker other than yourself?

Please think about multiple households in which you lived.

__ __ __ months (up to 3 characters, must be numbers entered)

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. Check the box next to the one best answer for each question.

Q34.A. How often have you had drinks containing alcohol?

- Never [GO TO [Q34.D](#)]
- Weekly
- Less than monthly
- Daily or almost daily
- Monthly

Q34.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 ½ ounces of 80-proof hard liquor.)

- 1 or 2
- 7 to 9
- 3 or 4
- 10 or more
- 5 or 6
- None

Q34.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 ½ ounces of 80-proof hard liquor.)

- Never
- Weekly
- Less than monthly
- Daily or almost daily
- Monthly

Q34.D. 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

Visit 59 CADI Form

Now you will be asked some questions about your sexual activity. We realize that this is a very personal subject. Your answers will be completely confidential.

Q35. Have you engaged in any sort of sexual activities involving another person since your last visit [in MONTH, YEAR]?

NO [GO TO Q42.1A] YES [GO TO Q36]

DEFINITION: SEXUAL ACTIVITY includes oral sex, anal or butt sex, vaginal sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

Q36. Have you had any sexual activity with a woman since your last visit [in MONTH, YEAR]?

NO [GO TO Q39] YES [GO TO Q37.A]

DEFINITION: SEXUAL ACTIVITY includes oral sex, anal or butt sex, vaginal sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

Q37.A. How many different women (if any) have you had sexual intercourse with since your last visit [in MONTH, YEAR]?

___ ___ ___ (up to 3 characters, must be numbers entered)

DEFINITION: Here we define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus or butt, with or without ejaculation.

Q37.B. With how many (other) women have you had sexual activity that did not include intercourse since your last visit [in MONTH, YEAR]?

___ ___ ___ (up to 3 characters, must be numbers entered)

DEFINITION: SEXUAL ACTIVITY without INTERCOURSE includes deep kissing and/or touching of genital or anal areas.

**IF ONLY 1 PARTNER (Q37.A + Q37.B = 1),
GO TO Q37.C1**

**IF ONLY 1 PARTNER (Q37.A + Q37.B ≥ 2),
GO TO Q37.C2**

Q37.C1. 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.
- Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with. [GO TO Q38.1A]

Visit 59 CADI Form

Q37.C2. 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 [Q38.1B](#)] YES [GO TO [Q37.D](#)]

Definition: SEXUAL ACTIVITY includes oral sex, anal or butt sex, vaginal sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

Q37.D. Did you have unprotected vaginal or anal intercourse with your main partner since your last visit [in MONTH, YEAR]?

NO YES

Q37.E. What is the HIV status of your main partner?

Negative Positive Don't Know

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

Q38. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.

	a.	b.
1.	Since your last visit [in MONTH, YEAR], did you put your penis in a woman's mouth (oral sex)? <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	Since your last visit [in MONTH, YEAR], with how many women did you put your penis in their mouth (oral sex)? <p style="text-align: center;">_ _ _ _</p>
2.	Since your last visit [in MONTH, YEAR], did you put your penis in a woman's vagina (vaginal sex)? <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p style="text-align: center;">[IF NO, GO TO Q38.4a]</p>	Since your last visit [in MONTH, YEAR], with how many women did you put your penis in their vagina (vaginal sex)? <p style="text-align: center;">_ _ _ _</p> <p style="text-align: center;">[IF 0, GO TO Q38.4b]</p>
3.	Did you use a condom <u>every time</u> for vaginal sex even if it broke, tore or slipped? <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	With how many of those women did you use a condom <u>every time</u> for vaginal sex, even if it broke, tore or slipped? <p style="text-align: center;">_ _ _ _</p>
4.	Since your last visit [in MONTH, YEAR], did you put your penis in a woman's anus or butt (anal sex)? <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p style="text-align: center;">[IF NO, GO TO Q38.6a]</p>	Since your last visit [in MONTH, YEAR], with how many women did you put your penis in their anus or butt (anal sex)? <p style="text-align: center;">_ _ _ (up to 3 characters, must be numbers entered)</p> <p style="text-align: center;">[IF "0," GO TO Q38.6b]</p>

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Q38. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.		
	a.	b.
5.	Did you use a condom every time for anal sex even if it broke, tore or slipped? <input type="checkbox"/> NO <input type="checkbox"/> YES	With how many of those women did you use a condom <u>every time</u> for anal sex, even if it broke, tore or slipped? _ _ _ _
6.	Since your last visit [in MONTH, YEAR], did you engage in deep wet kissing with a woman (where one of you put your tongue into the other's mouth)? <input type="checkbox"/> NO <input type="checkbox"/> YES	Since your last visit [in MONTH, YEAR], with how many women did you engage in deep wet kissing (where one of you put your tongue into the other's mouth)? _ _ _ (up to 3 characters, must be numbers entered)
7.	Since your last visit, did you use your tongue to touch or lick a woman's anus or butt ("rimming")? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF	Since your last visit, with how many women did you use your tongue to touch or lick their anus or butt ("rimming")? _ _ _ _ _ Number of partners <input type="checkbox"/> REF
8.	Since your last visit, did you use your tongue to touch or lick a woman's genitals (vagina, clitoris)? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF	Since your last visit, with how many women did you use your tongue to touch or lick their genitals (vagina or clitoris)? _ _ _ _ _ Number of partners <input type="checkbox"/> REF

Q39. Have you had any sexual activity with a man since your last visit [in MONTH, YEAR]?
 NO [IF NO, GO TO [Q41.10](#)] YES [IF YES, GO TO [Q40.a](#)]

Definition: SEXUAL ACTIVITY includes oral sex, anal or butt sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

Q40.a. How many different men (if any) have you had sexual intercourse with since your last visit [in MONTH, YEAR]?
 _ _ _ _ (up to 3 characters, must be numbers entered)

Definition: Here we define sexual intercourse as follows: you put your penis into your partner's mouth or anus or butt; or your partner puts his penis in your mouth or anus/butt, with or without ejaculation.

Q40.b. With how many (other) men have you had sexual activity that did not include intercourse since your last visit [in MONTH, YEAR]?
 _ _ _ _ (up to 3 characters, must be numbers entered)

Definition: SEXUAL ACTIVITY without INTERCOURSE includes deep kissing and/or touching of genital or anal areas.

**IF ONLY 1 PARTNER (Q40.a + Q40.b = 1),
GO TO Q40.c1**

**IF ONLY 1 PARTNER (Q40.a + Q40.b ≥ 2),
GO TO Q40.c2**

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Q40.c1. 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 [Q40.d](#)]
- Casual partner, one time partner, exchange partner, or someone with whom you have not developed a longstanding, close relationship with. [GO TO [Q41.a](#)]

Exchange partner: Someone you exchanged money or drugs with for sex.

Q40.c2 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 [IF NO, GO TO [Q41.b](#)] YES [IF YES, GO TO [Q40.d](#)]

Definition: SEXUAL ACTIVITY includes oral sex, anal or butt sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

Q40.d. Did you have unprotected anal intercourse with your main partner since your last visit [in MONTH, YEAR]?

- No Yes

Q40.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 [Q41.9](#)**

	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
1.	Since your last visit [in MONTH, YEAR] did you put your penis in another man's mouth? <input type="checkbox"/> NO <input type="checkbox"/> YES	Since your last visit [in MONTH, YEAR], with how many men did you put your penis in their mouth? ___ ___ (up to 3 characters, must be numbers entered)
2.	Since your last visit [in MONTH, YEAR] did you put your penis in another man's anus or butt? <input type="checkbox"/> NO <input type="checkbox"/> YES [IF NO, GO TO Q41.5a]	Since your last visit [in MONTH, YEAR], with how many men did you put your penis in their anus or butt? ___ ___ (up to 3 characters, must be numbers entered) [IF "0," GO TO Q41.5b]

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	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
3.	Thinking of the times you put your penis in his anus or butt, did you use a condom every time, even if it broke, tore or slipped? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>[IF YES (Protected Sex Only), GO TO Q41.4a2]</i>	Thinking of the times you put your penis in their anus or butt, with how many of those men did you use a condom <u>every time</u> even if it broke, tore or slipped? ___ __ (up to 3 characters, must be numbers entered) <i>[IF ONLY PROTECTED ANAL SEX (Q41.5b = Q41.6b), GO TO Q41.4b4]</i>
4.	1. What was the status of your partner when you did not use a condom? <input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Don't know	1. For those men with whom you did not use a condom, were any of these men HIV positive? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know
	2. Did you ejaculate or cum in his anus or butt when you did not use a condom (or when a condom failed)? <input type="checkbox"/> NO <input type="checkbox"/> YES	2. For those men with whom you did not use a condom, were any of these men HIV negative? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <i>[IF Q41.3b1 OR Q41.3b2 = DON'T KNOW OR NOT SURE, GO TO Q41.3b4]</i>
		3. Were you <u>unsure</u> of the HIV status of any of these men with whom you did not use a condom? <input type="checkbox"/> NO <input type="checkbox"/> YES
		4. With how many men did you ejaculate or cum in their anus or butt when you did <u>not</u> use a condom (or when a condom failed)? ___ __ (up to 3 characters, must be numbers entered)
5.	Since your last visit [in MONTH, YEAR], did another man put his penis in your mouth? <input type="checkbox"/> NO <input type="checkbox"/> YES	Since your last visit [in MONTH, YEAR], how many men put their penis in your mouth? ___ __ (up to 3 characters, must be numbers entered)
6.	Since your last visit [in MONTH, YEAR], did another man put his penis in your anus or butt? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>[IF NO, GO TO Q41.9a]</i>	Since your last visit [in MONTH, YEAR], how many men put their penis in your anus or butt? ___ __ (up to 3 characters, must be numbers entered) <i>[IF "0," GO TO Q41.9b]</i>
7.	Thinking of the times he put his penis in your anus or butt, was a condom used <u>every time</u> even if it broke, tore or slipped? <input type="checkbox"/> NO <input type="checkbox"/> YES <i>[IF YES (Protected Sex Only), GO TO Q41.7a2]</i>	Thinking of the times when a man put his penis in your anus or butt, with how many of those men was a condom used <u>every time</u> , even if it broke, tore or slipped? ___ __ (up to 3 characters, must be numbers entered) <i>[IF ONLY PROTECTED ANAL SEX (Q41.7b = Q41.6b), GO TO Q41.7b4]</i>

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	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
7.	<p>1. What was the HIV status of your partner when he did not use a condom?</p> <p><input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Don't know</p>	<p>1. Of the men who did not use a condom, were any of these men HIV positive?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know</p>
	<p>2. Did ejaculate or cum go into your anus or butt when he did not use a condom (or when a condom failed)?</p> <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>2. Of the men who did not use a condom, were any of these men HIV negative?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Don't Know <i>[IF Q41.7b1 OR Q41.7b2 = DON'T KNOW OR NOT SURE, GO TO Q41.7b4]</i></p>
		<p>3. Were you unsure of the HIV status of any of these men who did not use a condom?</p> <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p>
		<p>4. With how many men did ejaculate or cum go into your anus or butt when they did not use a condom (or when a condom failed)?</p> <p style="text-align: center;">___ ___ (up to 3 characters, must be numbers entered)</p>
9.	<p>Since your last visit [in MONTH, YEAR], did you engage in deep wet kissing with a man (where one of you put your tongue into the other's mouth)?</p> <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>Since your last visit [in MONTH, YEAR], with how many men did you engage in deep wet kissing (where one of you put your tongue into the other's mouth)?</p> <p style="text-align: center;">___ ___ (up to 3 characters, must be numbers entered)</p>
10.	<p>Since your last visit, did you use your tongue to touch or lick another man's anus or butt ("rimming")?</p> <p style="text-align: center;"><input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF</p>	<p>Since your last visit, with how many men did you use your tongue to touch or lick their anus or butt ("rimming")?</p> <p style="text-align: center;">___ ___ (up to 3 characters, must be numbers entered)</p>

Q41.10. Have you met any new partners with whom you had sexual intercourse since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.1a](#)] YES [IF YES, GO TO [Q41.11](#)]

We define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus or butt, with or without ejaculation

Q41.11. Where did you meet this last new partner?

- | | |
|--|---|
| <p><input type="checkbox"/> On the Internet</p> <p><input type="checkbox"/> Circuit party</p> <p><input type="checkbox"/> Through an advertisement in a newspaper or other newsletter</p> <p><input type="checkbox"/> At a bar</p> <p><input type="checkbox"/> At a bath house</p> | <p><input type="checkbox"/> In a park or other outdoor public place</p> <p><input type="checkbox"/> In a bathroom, bookstore, or other indoor place</p> <p><input type="checkbox"/> At a place where drugs were used or exchanged</p> <p><input type="checkbox"/> Group sex or sex party</p> <p><input type="checkbox"/> Other setting or source not listed above</p> |
|--|---|

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Q41.12. Which of the following drugs and alcohol, if any, did you use during sexual intercourse with this LAST NEW male or female sexual partner? (Please select all that apply to you.)

- No alcohol or drugs used
- Alcohol
- Marijuana
- Poppers
- Crystal methamphetamine
- GHB
- Ecstasy
- Powder cocaine
- Crack cocaine
- Viagra, Levitra, and/or Cialis
- Injectable Caverjet or TriMix
- Herbal supplements to promote erection
(Ginseng, Ginkgo Biloba, Yohimbe Bark Extract)
- Other drug not listed above

Q41.13. How often have you used condoms with this LAST NEW male or female sexual partner?

- Always Sometimes Never

The next series of questions are related to recreational or street drugs you may have used since your last visit [in MONTH, YEAR].

Q42.1a. Have you taken or used any pot, marijuana or hash since your last visit [in MONTH, YEAR]?

- NO [IF NO, GO TO [Q42.2a](#)] YES [IF YES, GO TO [Q42.1b](#)]

Q42.1b. How often did you use or take pot, marijuana or hash since your last visit [in MONTH, YEAR]?

- Daily Monthly
 Weekly Less often

Q42.1c. What were the reasons for using pot? Select all that apply.

- For medical reasons
- For recreational reasons, not including sex
- For sexual enhancement reasons
- To increase ability to socialize
- To fit in with a group

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Q42.2a. Have you taken or used any “poppers” like nitrate inhalants (amyl, butyl, or isopropyl nitrites) since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.3a](#)] YES [IF YES, GO TO [q42.2b](#)]

Q42.2b. How often did you use or take “poppers” like nitrate inhalants (amyl, butyl, or isopropyl nitrites) since your last visit [in MONTH, YEAR]?

Daily Monthly
 Weekly Less often

Q42.3a. Have you taken or used any crack or cocaine that you smoke since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.4a](#)] YES [IF YES, GO TO [Q42.3b](#)]

Q42.3b. How often did you use or take crack or cocaine that you smoke since your last visit [in MONTH, YEAR]?

Daily Monthly
 Weekly Less often

Q42.4a. Have you taken or used any other forms of cocaine since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.5a](#)] YES [IF YES, GO TO [Q42.4b](#)]

Q42.4b. How often did you use or take other forms of cocaine since your last visit [in MONTH, YEAR]?

Daily Monthly
 Weekly Less often

Q42.4c.) How did you use or take other forms of cocaine since your last visit [in MONTH, YEAR]? (Select all that apply).

Snorted Put in anus (“booty bumped”)
 Swallowed Injected (intravenous use)

Q42.5a.) Have you taken or used any speed, meth or ice since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.6a](#)] YES [IF YES, GO TO [Q42.5b](#)]

Q42.5b. How often did you use or take speed, meth or ice since your last visit [in MONTH, YEAR]?

Daily Monthly
 Weekly Less often

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Q42.5c. How did you use or take speed, meth or ice since your last visit [in MONTH, YEAR]? (Select all that apply).

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Snorted | <input type="checkbox"/> Put in anus (“booty bumped”) |
| <input type="checkbox"/> Swallowed | <input type="checkbox"/> Injected (intravenous use) |
| <input type="checkbox"/> Smoked | |

Q42.6a. Have you taken or used any heroin since your last visit [in MONTH, YEAR]?

- NO [IF NO, GO TO [Q42.7a](#)] YES [IF YES, GO TO [Q42.6b](#)]

Q42.6b. How often did you use or take heroin since your last visit [in MONTH, YEAR]?

- | | |
|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Less often |

Q42.6c. How did you use or take heroin since your last visit [in MONTH, YEAR]?(Select all that apply.)

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Snorted | <input type="checkbox"/> Put in anus (“booty bumped”) |
| <input type="checkbox"/> Swallowed | <input type="checkbox"/> Injected (intravenous use) |
| <input type="checkbox"/> Smoked | |

Q42.7a. Have you taken or used any speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]?

- NO [IF NO, GO TO [Q42.9a](#)] YES [IF YES, GO TO [Q42.7b](#)]

Q42.7b. How often did you use or take speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]?

- | | |
|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Less often |

Q42.7c. How did you use or take speedball (heroin and cocaine together) since your last visit [in MONTH, YEAR]?(Select all that apply).

- | | |
|------------------------------------|---|
| <input type="checkbox"/> Snorted | <input type="checkbox"/> Put in anus (“booty bumped”) |
| <input type="checkbox"/> Swallowed | <input type="checkbox"/> Injected (intravenous use) |
| <input type="checkbox"/> Smoked | |

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Q42.9a) Have you taken or used any sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q42.10a](#)] YES [IF YES, GO TO [Q42.9b](#)]

Definition: Sexual performance enhancing drugs include Viagra, Herbal Viagra, Levitra, Cialis, Testosterone patch, injection or topical creams, Yohimbine, Ephedrine or Guarana containing products, Tri-Mix, Penile suppositories, or any other compound, herbal preparation or prescription drug used primarily to enhance sexual performance in the absence of diagnosed primary erectile dysfunction.

Q42.9b. How often did you use or take sexual performance enhancing drugs **other than those prescribed by a medical provider** for diagnosed erectile dysfunction since your last visit [in MONTH, YEAR]?

Daily Monthly
 Weekly Less often

42.10a. How about other kinds of street or club drugs, have you taken or used any since your last visit [in MONTH, YEAR]?

NO [IF NO, GO TO [Q44.a](#)] YES [IF YES, GO TO [Q42.10b](#)]

42.10b. Please select all the other kinds of street or club drugs that you have taken or used since your last visit and how often you have used them since your last visit [in MONTH, YEAR]. This is for non-prescription drugs only.

- "Downers" including barbiturates, yellow jackets or reds, tranquilizers like Valium, Librium, Xanax or other sedatives or hypnotics like Quaaludes.
- Methadone or other opiates or narcotics like Demerol
- PCP, angel dust, psychedelics, hallucinogens, LSD, DMT, mescaline, Ketamine or special K
- Ethyl Chloride as an inhalant
- GHB
- Other

Specify: _____

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42.10c. Which street drugs did you take and how often. How often did you use or take street or club drugs since your last visit [in MONTH, YEAR]?

	Daily	Weekly	Monthly	Less Often
“Downers” including barbiturates, yellow jackets or reds, tranquilizers like Valium, Librium, Xanax or other sedatives or hypnotics like Quaaludes.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Methadone or other opiates or narcotics like Demerol	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
PCP, angel dust, psychedelics, hallucinogens, LSD, DMT, mescaline, Ketamine or special K	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ethyl Chloride as an inhalant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
GHB	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

[IF NO INJECTING DRUG USE, GO TO Q45]

Q43. You mentioned that since your last visit [in MONTH, YEAR] you have injected recreational drugs. Are you currently injecting drugs?

NO YES

Q44.a. Since your last visit [in MONTH, YEAR], have you participated in a needle exchange program?

NO *[IF NO, GO TO Q45]* YES *[IF YES, GO TO Q44.b]*

Q44.b. Of the times you obtained needles, how often did you get them from a needle exchange?

Less Than Half The Time Most Of The Time
 Half The Time Always

Q45. 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

END CADI