

Visit 65 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 Andrea Stronski (astrons2@jhu.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. Administer all embedded questions within a skip pattern for abbreviated interview questions.**

* MACSID NUMBER (enter twice) _____

* Visit Number: V065

* TIME BEGAN				
HOUR		MINUTES		AM/PM

* DATE OF VISIT					
MONTH		DAY		YEAR	

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

* Date of birth [**MM/DD/YYYY**] ____ / ____ / _____ (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's 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. 1 st Cancer	2. 2 nd 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)]?	____ / ____ 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:		
Code:	____ . ____	____ . ____

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	1. 1 st Diagnosis	2. 2 nd Diagnosis
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

Q3NOTES:
Clinician's Notes: Method of Diagnosis (30 Characters)

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? ___/___/___ [MM/YYYY]

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)]?

[If a participant reports that he was hospitalized for a reportable outcome, request medical records]

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. Leading zeroes for ICDS-cm codes.

- “V”= no disease or injury (e.g., organ donation)
“E”= external causes of injury (e.g., car accident)
“P”= procedures (enter leading zero)
“NP”= no prefixes (all other diagnosis)

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. Leading zeroes for ICDS-cm codes.

“V”= no disease or injury (e.g., organ donation)

“E”= external causes of injury (e.g., car accident)

“P”= procedures (enter leading zero)

“NP”= no prefixes (all other diagnosis)

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	

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

____ / ____ / ____
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. Leading zeroes for ICDS-cm codes.

“V”= no disease or injury (e.g., organ donation)

“E”= external causes of injury (e.g., car accident)

“P”= procedures (enter leading zero)

“NP”= no prefixes (all other diagnosis)

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

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.

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Q6.B4c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R's OWN WORDS. Leading zeroes for ICDS-cm codes.

“V”= no disease or injury (e.g., organ donation)

“E”= external causes of injury (e.g., car accident)

“P”= procedures (enter leading zero)

“NP”= no prefixes (all other diagnosis)

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

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 anal 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]

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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.

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

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

***Q9.B.** Since your last visit [in (MONTH, YEAR)], has a doctor or medical practitioner inserted a tube-shaped device or scope in your anus or rectum to look for hemorrhoids, fissures, infections and some cancers? This is also known as a High Resolution Anoscopy (HRA).

NO

YES

DON'T KNOW

REF

If yes or don't know, request medical records. If an HRA was performed based on the review of the medical records, fill out an HRA Outcome Reporting form to indicate if a biopsy was performed and the biopsy results. Submit to CAMACS. See MACS forum for protocols.

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

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

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

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

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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**]

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 Weekly Monthly 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. **If reported cancer, ask about biopsy for the cancer.**

- NO [**GO TO Q9.10A**]
- YES [**GO TO Q9.D2**]
- REF [**GO TO Q9.10A**]

Medical Release Obtained? (See Q1)

REF 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:

- | | | | | |
|--|-----------------------------|------------------------------|-----------------------------|------------------------------|
| <ul style="list-style-type: none"> ▪ Rheumatoid | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| <ul style="list-style-type: none"> ▪ Osteoarthritis or Degenerative | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| <ul style="list-style-type: none"> ▪ 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.

- | | | | |
|---|-----------------------------|------------------------------|------------------------------|
| *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 |
| *Q. A blood clot in your legs | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| *R. Kidney disease/Renal failure | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |
| *S. Elevated Liver Enzyme | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> REF |



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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. **Both sets are listed below. Only complete the baseline for participants who have not been administered this section in the past. Otherwise, skip to the Bone Strength Sub Study question (T1).**

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 (IF the participant was administered these questions at V61, then go to Q10.fam – Since Last Visit)

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.fam – Since Last Visit

1. Since your last visit, has a male member of your immediate family

a) 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) 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

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2. Since your last visit has a female member of your immediate family

a) 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) 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. Since your last visit has a male member of your immediate family

a) 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

b) 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. Since your last visit has a female member of your immediate family

a) 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

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b) 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
-

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

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

IF YES:

T1b. Have you reported all of your falls to the clinic? NO YES DK REF

IF yes, go to T.2.Intro. (If **NO** falls occurred, answer **YES**)

IF NO OR DK:

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

***T.2.Intro** “We are now going to ask you some questions about falls that may have happened during your usual daily activities. For the following questions, by “a fall” or “falling”, we mean an unexpected event, including a slip or trip, in which you lost your balance and landed on the floor, ground or lower level, or hit an object like a table or chair. Falls that result from a major medical event (for example, a stroke, or seizure) or an overwhelming external hazard (for example, hit by a truck or pushed) should not be included.”

T.2a. Since your last visit, have you been concerned with losing your balance and falling while doing your usual daily activities? Would you say not at all, a little, quite a bit or very much?

- | | |
|--------------------------------------|------------------------------------|
| <input type="checkbox"/> NOT AT ALL | <input type="checkbox"/> VERY MUCH |
| <input type="checkbox"/> A LITTLE | <input type="checkbox"/> DK |
| <input type="checkbox"/> QUITE A BIT | <input type="checkbox"/> REF |

T.2b. How many times have you fallen since your last visit?

- None *Go to Q10. (cont.)*
 1 time
 2 times
 3-5 times
 More than 5 times
 DK
 REF

T.2c. Did you seek medical attention after any of these falls (such as calling 911, going to the emergency room or to a doctor's office)? **INTERVIEWER NOTE:** Answer “No”, if the participant did not see a medical provider (nurse, physician, paramedic, etc.) in-person. For example, answer NO if he asked a friend for advice, or contacted a medical provider, but was not examined by one.

- NO YES DK REF

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***T3.** Since your last visit, Broken or fractured bones NO YES REF

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

***T4.** What was fractured? _____

[See Appendix Q9A in
Guidelines for ICD9 codes]

***T5.** 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? _____

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Q10.CCc. Heart and Blood Vessels [Ask if in CV2 study and it had follow up. If yes, get medical release]

NO YES REF

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

IF YES: Was there a diagnosis?

NO YES REF

What was the diagnosis? _____

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? _____

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

Q10.CCe. Esophagus, 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: ____/____/____
Month Day Year

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

Visit 65 CADI Form

Q10.CCg. Genital, Urinary and Rectal

NO YES REF

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

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:** ____ / ____ / ____
Month Day Year

Q10.CCj. Treatment of depression, anxiety, or other mental 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? _____

Visit 65 CADI Form

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? _____

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 OR REF 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

Visit 65 CADI Form

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

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

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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?
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
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

Visit 65 CADI Form

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.

Q14.1. Since your last visit, [in (MONTH, YEAR)], have you been given **a vaccine or a therapeutic vaccine to control HIV infection** as part of a research trial?

Preventive trials study the efficacy of vaccines developed to prevent HIV infection and therapeutic vaccine trials study the efficacy of vaccines to control HIV infection by boosting the body's natural immune response and sometimes delaying the need for initiating antiretroviral drug treatment.

NO YES REF

[IF NO OR REF, 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]

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.

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

Name of Hospital/clinic or doctor: _____

ADDRESS: _____

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

Q14.3. MACS CODE for Clinical/Vaccine Trial: _____

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

Visit 65 CADI Form


* **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.) This does not include medications to prevent getting infected with HIV. Questions about this type of treatment are asked separately. Interviewer Note: [If HIV negative participants reports ART drug(s), this information will be collected in Prep| Pep section]

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 |

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 DK 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 [GO TO [Q15.C1](#)] YES REF [GO TO [Q15.C1](#)]

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

Fill out a separate Drug Form 1 form for each reported drug taken since last visit. This drug form also contains adherence questions about the reported drug. NOTE- USE THE CADI COMPATIBLE PAPER FORMS ONLY. DO NOT USE THE SCAN FORM.

Visit 65 CADI Form

Administer DRUG Forms and Adherence questions 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

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"/>

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Q3.	Never	Rarely	Sometimes	Often	Refuse
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 |

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?

- | | |
|---|---|
| <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 |

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:			

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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](#)]

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

Name: _____

Code: _____

Name: _____

Code: _____

Name: _____

Code: _____

If abbreviated interview, go to Q16.1A-D and Q16.11-16.15, Q25a-25b..

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](#)

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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.

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

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3) Under skin pellet (Testopel)

NO YES REF

IF YES:

Have you had a pellet placed in the last 6 months?

NO YES REF

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](#)]

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

YES

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

OTHER

Specify: _____

If YES or OTHER:

Q16.2B. 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 REF

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](#)]

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

YES

REF [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

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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 and 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 OR REF, 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 OR REF, 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
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

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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? NO YES REF

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

- YES REF [GO TO [Q16.6A](#)]
 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 65 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)?
<p>9. Acyclovir, famciclovir or valacyclovir for herpes (zovirax, famvir, valtres)</p> <p>IF YES, did you take it:</p> <p>Everyday <input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p>Only when you had active lesions or outbreak? <input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	<hr/> <hr/>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<p>10. Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	<hr/> <hr/>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<p>*11. Aspirin taken three days or more on a weekly basis</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES	<hr/> <hr/>	<input type="checkbox"/> NO <input type="checkbox"/> YES
<p>*12. Medications to lower cholesterol, triglycerides, lipids or blood fat</p> <p>_____</p> <p>_____</p> <p>_____</p>	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES	<hr/> <hr/> <hr/>	<input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> YES
<p>*13. Medications to treat hypertension</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<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	<hr/> <hr/> <hr/> <hr/> <hr/>	<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

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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)?
<p>*14. Medications to treat diabetes</p> <p style="text-align: center;">-----</p> <p style="text-align: center;">-----</p> <p style="text-align: center;">-----</p>	<p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>
<p>*15. Medications to treat hepatitis</p> <p style="text-align: center;">-----</p> <p style="text-align: center;">-----</p>	<p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>	<p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p><input type="checkbox"/> NO <input type="checkbox"/> YES</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES</p>

Visit 65 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?
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
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

Visit 65 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?
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

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

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

NO YES REF

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

Visit 65 CADI Form

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 DK REF

[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

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.**]

Please include all doctor visits and any other outpatient visits or services for each of your reported illness, and any additional illness.

Source for Medical Care	Have you used...	How many times?
1) Doctor's office or any other clinic, including specialty clinic and Urgent Care	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
2) Emergency Room	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
3) Other outpatient service: facilities providing lab work, imaging, or non-mental health	<input type="checkbox"/> NO <input type="checkbox"/> YES	___ ___
<i>Specify Other:</i>		

Visit 65 CADI Form

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? _____

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**]

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:

Visit 65 CADI Form

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. Depression and social support scales]”

- CADI Interview
- MWII (ACASI)
- Participant Refused behavior section

***Q25a.** Telephone interview? NO YES

***Q25b.** Limited visit? NO YES

***Q26.** Home visit? NO YES

If abbreviated interview, administer smoking session (Q33a1 – Q33G) before ending questionnaire.

Q27. Interview Method

- Interview conducted on a paper form then entered into CADI

Q27.a. Abbreviated interview? NO YES

Q28. DATE INTERVIEW WAS COMPLETED: ___ ___ / ___ ___ / ___ ___ ___ ___ (MM/DD/YYYY)

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

Q29. Time ended: Hours ___ ___
Minutes ___ ___
AM/PM ___

Interviewers name:

Last name _____
First Name _____
INTERVIEWER’S NUMBER ___ ___ ___

Choose clinic:

- | | | |
|--|--------------------------------------|--|
| <input type="checkbox"/> BA Share Clinic | <input type="checkbox"/> CH CORE | <input type="checkbox"/> LA LAGLC |
| <input type="checkbox"/> BA Whitman Walker | <input type="checkbox"/> PI | <input type="checkbox"/> LA Harbor |
| <input type="checkbox"/> CH Howard Brown | <input type="checkbox"/> PI (Ohio) | <input type="checkbox"/> LA Satellite Clinic |
| <input type="checkbox"/> CH Northwestern | <input type="checkbox"/> LA Wilshire | |

Visit 65 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 REMEMBER OR IF HIV INFECTED OR REF, 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"/> DK <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> DK <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 65 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"/> DK | <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <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 |

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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"/> DK | <input type="checkbox"/> REF |
| 2) More than 12 hours before having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| 3) Within 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <input type="checkbox"/> REF |
| 4) More than 12 hours after having sex | <input type="checkbox"/> NO | <input type="checkbox"/> YES | <input type="checkbox"/> DK | <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 |

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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

[IF NO OR REF, GO TO [Q32](#)]

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

- Less Same Greater 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 OR REF, 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.

NOTE - Administer the smoking session if this is an abbreviated interview. Then end interview on pages 38-39.

***Q33.A1.** Have you ever smoked cigarettes?

- NO [GO TO **Q33.d**] YES [GO TO **Q33.A2**] REF [GO TO **Q33.d**]

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
 REF

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**]
 REF [GO TO **Q33.d**]

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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
- REF

Q33.D. Since your last visit, [in MONTH, YEAR], have you smoked E-cigarettes?

- NO YES Occasionally (less than one cigarette per day) REF

Q33.E. Are you smoking them now?

- NO YES Occasionally REF

Q33.F. Since your last visit [in MONTH YEAR], have you used any stop-smoking medications, such as patch, gum, nasal spray, inhalers, or lozenges?

- NO YES Occasionally REF

Q33.G. 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?

- | | |
|---|---|
| <input type="checkbox"/> Never [GO TO Q34.D] | <input type="checkbox"/> Weekly |
| <input type="checkbox"/> Less than monthly | <input type="checkbox"/> Daily or almost daily |
| <input type="checkbox"/> Monthly | <input type="checkbox"/> REF [GO TO Q34.D] |

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.)

- | | |
|---------------------------------|-------------------------------------|
| <input type="checkbox"/> 1 or 2 | <input type="checkbox"/> 10 or more |
| <input type="checkbox"/> 3 or 4 | <input type="checkbox"/> None |
| <input type="checkbox"/> 5 or 6 | <input type="checkbox"/> REF |
| <input type="checkbox"/> 7 to 9 | |

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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 Daily or almost daily
 Less than monthly REF
 Monthly
 Weekly

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 REF

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.

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)

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)

IF 0 PARTNERS (Q37.A + Q37.B = 0), GO TO Q40.a

Q37.B.1. How many of your female sexual partners, if any, have you met since your last visit?

Q37.B.1 should be <= to Q37.A. + Q37.B.

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

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

**IF MORE THAN 1 PARTNER (Q37.A + Q37.B
≥ 2), GO TO Q38**

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

The next questions are about different kinds of sexual activity some men engage in with women.

Only one woman with NO intercourse, go to column a - 38.2a.

Only one woman with intercourse), go to column a - 38.1a.

Two or more women with NO intercourse, go to column b - 38.2b.

Two or more women with intercourse), go to column b - 38.1b.

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 have unprotected vaginal or anal intercourse (did not use a condom) with this partner? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF	Since your last visit [in MONTH, YEAR], with how many of these women did you have unprotected vaginal or anal intercourse (did not use a condom)? <p style="text-align: center;">_ _ _ _</p>
2.	Since your last visit [in MONTH, YEAR], did you use your tongue to touch or lick her genitals (vagina, clitoris)? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF	Since your last visit [in MONTH, YEAR], with how many of these women did you use your tongue to touch or lick her genitals (vagina, clitoris)? <p style="text-align: center;">_ _ _ _</p>
3.	What is the HIV status of this partner? <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DON'T KNOW [GO TO Q.40.a.]	Was one of these women your main partner? (A main partner is someone you have a longstanding relationship with, live with or partner with.) <input type="checkbox"/> NO [GO TO Q.40.a.] <input type="checkbox"/> REF [GO TO Q.40.a.] <input type="checkbox"/> YES [GO TO Q38.b.4]

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Q38. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.		
	a.	b.
4.		Did you have <u>unprotected</u> vaginal or anal intercourse with your main partner since your last visit? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
5.		What is the HIV status of your main partner? <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DON'T KNOW

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)

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)

IF 0 PARTNERS (Q40.a + Q40.b = 0), GO TO Q42.1.b.

Q40.c. How many of your male sexual partners, if any, have you met since your last visit?

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

Q40.c. must be <= (Q40.a. + Q40b)

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

IF MORE THAN 1 PARTNER (Q40.a + Q40.b ≥ 2), GO TO Q41

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.
- Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with.
- Exchange partner: Someone you exchanged money or drugs with for sex

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The next questions are about different kinds of sexual activity some men engage in with other men.

IF NO INTERCOURSE WITH MEN, SKIP TO [Q42.1.b](#) (drug section)

Only one man with NO intercourse, go to column a - [Q41.3a](#)

Two or more men with NO intercourse, go to column a - [Q41.3b](#).

Only one man with intercourse, go to column b - [Q41.1a](#)

Two or more men with intercourse go to column b - [Q41.1b](#)

Q41.	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
1.	a.	b.
1.	<p>Since your last visit [in MONTH, YEAR] did you have unprotected INSERTIVE anal intercourse with this partner (put your penis in his anus or butt without a condom)?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF</p>	<p>Since your last visit [in MONTH, YEAR], with how many men did you have unprotected INSERTIVE anal intercourse (put your penis in their anus or butt without a condom)?</p> <p>** Q41.1.b must be <= Q40.a**</p> <p>____ (up to 3 characters, must be numbers entered)</p>
2.	<p>Since your last visit [in MONTH, YEAR], did you have unprotected RECEPTIVE anal intercourse with this main partner (put his penis in your anus or butt without a condom)?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF</p>	<p>Since your last visit [in MONTH, YEAR], with how many men you have unprotected RECEPTIVE anal intercourse (put their penis in your anus or butt without a condom)?</p> <p>** Q41.2.b must be <= Q40.a**</p> <p>____ (up to 3 characters, must be numbers entered)</p>
3.	<p>Since your last visit [in MONTH, YEAR], did this man put his penis in your mouth?</p> <p><input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF</p>	<p>Since your last visit [in (MONTH, YEAR)], how many of these unprotected INSERTIVE and/or RECEPTIVE anal intercourse partners were?</p> <p><input type="checkbox"/> HIV negative ____</p> <p><input type="checkbox"/> HIV positive ____</p> <p><input type="checkbox"/> You are unsure about? ____</p> <p>**Please enter a number for each of these boxes (enter 0 if none). They should add up to the total number of partners with whom you had unprotected insertive and/or receptive intercourse since your last visit. **</p>

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	IF ONLY ONE PARTNER: USE COLUMN a.	IF MULTIPLE PARTNERS: USE COLUMN b.
Q41.	a.	b.
4.	Since your last visit [in MONTH, YEAR], did you put your penis in this man's mouth? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF	Since your last visit [in (MONTH, YEAR)], how many men put their penis in your mouth? ** Q41.4.b must be <= Q40.a + Q40.b** _ _ _ (up to 3 characters, must be numbers entered)
5.	What is the HIV status of this partner? <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DON'T KNOW [GO TO Q.42.1b. (drug section)]	Since your last visit [in (MONTH, YEAR)], with how many men did you put your penis in their mouth? ** Q41.5.b must be <= Q40.a + Q40.b** _ _ _ (up to 3 characters, must be numbers entered)
6.		Since your last visit [in (MONTH, YEAR)], was one of your partners your main partner? This includes any partner with whom you had sexual intercourse or other sexual activity. A main partner is defined as a partner you have a longstanding relationship with, live with, or partner with. <input type="checkbox"/> NO [GO TO Q.42.1b.] <input type="checkbox"/> REF [GO TO Q.42.1b.] <input type="checkbox"/> YES
7.		Did you have unprotected sexual intercourse with your main partner since your last visit? <input type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> REF
8.		What is the HIV status of your main partner? <input type="checkbox"/> NEGATIVE <input type="checkbox"/> POSITIVE <input type="checkbox"/> DON'T KNOW

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

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

- | | |
|---------------------------------|-------------------------------------|
| <input type="checkbox"/> Daily | <input type="checkbox"/> Monthly |
| <input type="checkbox"/> Weekly | <input type="checkbox"/> Less often |
| <input type="checkbox"/> Never | |

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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

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
- Weekly
- Never
- Monthly
- Less often

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

- Daily
- Weekly
- Never
- Monthly
- Less often

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

- Daily
- Weekly
- Never [GO TO [Q42.5.a.](#)]
- Monthly
- 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
- Swallowed
- Put in anus (“booty bumped”)
- Injected (intravenous use)

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

- Daily
- Weekly
- Never [go to [Q42.6.a.](#)]
- Monthly
- Less often

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

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

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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](#)] REF [IF REF, GO TO [Q42.7a](#)]

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](#)] REF [IF REF, GO TO [Q42.9a](#)]

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 | |

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](#)] REF [IF REF, GO TO [Q42.10a](#)]

<p>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.</p>

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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]?

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

Q42.10b. 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
- None [**GO TO Q43.**]

Specify: _____

Q42.10c. 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]

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

NO YES REF

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 REF

END CADI