PWA Short Telephone Interview

ID #: ___ ___ ___ ___ ___ Date: ___/___/___

If contact was established but participant unable or unwilling to complete the questionnaire, check here: _____ Visit #: _____

1. Has your address changed since your last contact with us? Yes No
If yes, what is your new address?

_____

_____

2. Have you had any serious illness(es) or significant symptoms since your last contact with us? If YES, briefly describe all illnesses below. Details are especially helpful on any AIDS diagnoses, cancer or neurologic conditions:

Illness/Symptoms	MM	DD	YY	ICD - 9

3. At any time (since your last visit in [Month]) did you stay overnight as a patient in a hospital? Yes No

4. Name and address of the doctor and/or hospital that we may contact for further information: (Any information that you provide will be helpful.)

Dr. Name:	Telephone:
Address:	City:
Hospital/Address:	City:
Admission Dates:	

5. Do you have any kind of health insurance coverage or Medical Assistance? Yes No

a) Coverage by an HMO	Yes	No
b) Private Insurance (Blue Cross, CIGNA, etc.) (not an HMO)	Yes	No
c) Individual Private Insurance (Blue Cross, CIGNA, etc.) (not an HMO)	Yes	No
d) Medicaid, Medi-Cal or Medical Assistance	Yes	No
e) Medicare (for people over 65 or permanently disabled)	Yes	No
f) Health care benefits from the Armed Forces or Veteran's Administration	Yes	No
g) CHAMPUS or CHAMP-VA - medical insurance for dependents of military personnel or survivors or disabled veterens.	Yes	No
h) Other:	Yes	No

6. Where do you usually go for medical care, even if you haven't received medical care since your last visit? (*read all the choices, but circle only one*)

HMO Office (1) Any Clinic (3) Emergency Room (4)

Non-HMO Doctor's Office (2) No regular source of medical care (6) Don't know (7)

Other outpatient clinic (specify): _____ (5)

7. Are you taking any of the following medications to help fight AIDS or HIV infection?

Abacavir (Ziagen)	Yes	No	Indinavir (Crixivan)	Yes	No
Adefovir (Preveon)	Yes	No	Nelfinavir (Viracept)	Yes	No
Amprenavir (Agenerase)	Yes	No	Nevirapine (Viramune)	Yes	No
AZT (Retrovir)	Yes	No	Delavirdine (Rescriptor)	Yes	No
ddI (Videx)	Yes	No	Sustiva (Efavirenz)	Yes	No
ddC (HIVID)	Yes	No	Clarithromycin (Biaxin)	Yes	No
d4T (Zerit, Stavudine)	Yes	No	Bactrim	Yes	No
3TC (Epivir, Lamivudine)	Yes	No	Fluconazole (Diflucan)	Yes	No
Combivir (AZT & 3TC)	Yes	No	Dapsone	Yes	No
Saquinavir (Invirase, Fortovase)	Yes	No	Hydroxyurea (Hydrea)	Yes	No
Ritonavir (Norvir)	Yes	No	Trizivir (AZT + 3TC + Abacavir)	Yes	No

8. Please name any other drugs or substances that you are taking to help fight, prevent or treat any HIV related conditions:

_____

_____

9. Have you noticed new problems remembering things in the past six months? Yes No

If yes: a) Do you need to keep lists or rely on other people to remember things? Yes No

b) Can you remember what you read or watch on TV? Yes No

10. What is your employment status? (Circle one)

Working Full-time (35 hours or more per week) (1) Unemployed (3) Retired (5)

Working Part-time (less than 35 hours per week) (2) Disabled (4)

11. As usual, we are asking for the names and phone numbers of two contacts who do not live with you but who would always know your whereabouts.

Contact #1

_____

_____ Phone ( )

Contact #2

_____

_____ Phone ( )

Note: We will be sending you a medical records release form to sign. It is especially important to have a current one for our participants who have experience a recent illness. We hope you will return it to us as soon as possible. Thank you!