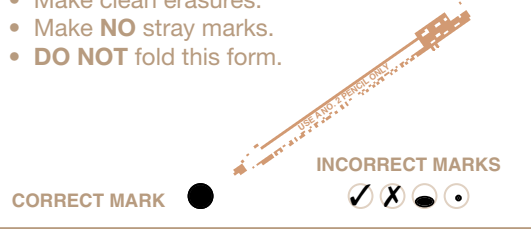


MARKING INSTRUCTIONS

- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make **NO** stray marks.
- **DO NOT** fold this form.



ID NUMBER				VISIT NO.			TIME BEGAN			DATE		
							HR	MIN		MONTH	DAY	YEAR
				3	8	0				<input type="radio"/> Jan		
				<input type="radio"/> 0	<input checked="" type="radio"/> 1	<input type="radio"/> 2				<input type="radio"/> Feb		
1	1	1	1	1	1	1	10	1	10	<input type="radio"/> Mar	0	0
2	2	2	2	2	2	2		20	2	<input type="radio"/> Apr	1	1
3	3	3	3	<input checked="" type="radio"/> 3	<input type="radio"/> 4	<input type="radio"/> 5		30	3	<input type="radio"/> May	2	2
4	4	4	4	4	4	4		40	4	<input type="radio"/> June	3	3
5	5	5	5	5	5	5		50	5	<input type="radio"/> July	4	4
6	6	6	6	6	6	6		6	6	<input type="radio"/> Aug	5	5
7	7	7	7	7	7	7		7	7	<input type="radio"/> Sept	6	6
8	8	8	8	<input checked="" type="radio"/> 8	<input type="radio"/> 9	<input type="radio"/> 0		8	8	<input type="radio"/> Oct	7	7
9	9	9	9	9	9	9		8	8	<input type="radio"/> Nov	8	8
								9	9	<input type="radio"/> Dec	9	9

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

IF "NO" TO a, GO TO NEXT ROW	a	b	c
	NO YES	In what month and year (since your last visit), was it [first] diagnosed?	How many times were you diagnosed with this since your last visit? FOR 9 OR MORE TIMES CODE "9"
A. Kaposi's sarcoma or KS	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	
B. Pneumocystis carinii pneumonia (PCP)	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	1 2 3 4 5 6 7 8 9
C. Other pneumonia, specify <input type="radio"/> Pneumococcal <input type="radio"/> Other bacterial <input type="radio"/> Viral <input type="radio"/> Other Specify: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	1 2 3 4 5 6 7 8 9 If more than 1 time, in what month and year was the most recent episode? Specify: <input type="text"/>
D. Toxoplasmosis or Toxo infection	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	
E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it? CODE ALL THAT APPLY. (DO NOT CODE "YES" IF ONLY CMV ANTIBODIES.) <input type="radio"/> Eyes <input type="radio"/> Lung <input type="radio"/> Colon <input type="radio"/> Other (not blood) Specify: <input type="text"/>	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	1 2 3 4 5 6 7 8 9
F. Mycobacterial infection (MAC, MAI or atypical TB)	<input type="radio"/> NO <input type="radio"/> YES GO TO NEXT ROW	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03	

GET MEDICAL RELEASE

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

3/8" spine part

1. Continued

IF "NO" TO a, GO TO NEXT ROW	a	b In what month and year was it first diagnosed since your last visit?																										
G. Lymphoma, specify <input type="radio"/> Primary brain lymphoma <input type="radio"/> Non-Hodgkin's <input type="radio"/> Other Specify: <input type="text"/>	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03																
H. Meningitis related to HIV or cryptococcal meningitis	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03																
I. Candida or thrush, a yeast infection of the esophagus, not just your mouth	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03																
J. Cryptosporidiosis	NO <input type="radio"/> YES <input type="radio"/> GO TO NEXT ROW	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03																
K. Wasting Syndrome or severe weight loss	NO <input type="radio"/> YES <input type="radio"/> GO TO Q 2	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03																

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

Name of hospital/clinic or doctor

Address

City

State

2. [Since your last visit in (MONTH)] In addition to these diagnoses, has a doctor or medical practitioner told you that you have had any other AIDS conditions?

- No → **SKIP TO Q 3**
- Yes ↓

a IF "YES": What was the diagnosis?	b In what month and year was it first diagnosed since your last visit?																										
1) Specify: <input type="text"/>	<table border="1"> <tr> <td><input type="text"/></td> <td>J</td><td>F</td><td>M</td><td>A</td><td>M</td><td>J</td><td>J</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td> </tr> <tr> <td><input type="text"/></td> <td>92</td><td>93</td><td>94</td><td>95</td><td>96</td><td>97</td><td>98</td><td>99</td><td>00</td><td>01</td><td>02</td><td>03</td> </tr> </table>	<input type="text"/>	J	F	M	A	M	J	J	A	S	O	N	D	<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03
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<input type="text"/>	92	93	94	95	96	97	98	99	00	01	02	03															

3. [Since your last visit in (MONTH)] Has a doctor or medical practitioner told you that you had some form of cancer (excluding Kaposi's sarcoma, primary brain lymphoma and non-Hodgkin's lymphoma)?

No → IF "NO," GO TO Q 4

Yes

a IF YES: What kind of cancer did they say it was?	b In what month and year was it first diagnosed since your last visit?																										
1) Site <input style="width: 100%;" type="text"/> Type <input style="width: 100%;" type="text"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border: 1px solid black;"></td> <td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">F</td><td style="border: 1px solid black;">M</td><td style="border: 1px solid black;">A</td><td style="border: 1px solid black;">M</td><td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">A</td><td style="border: 1px solid black;">S</td><td style="border: 1px solid black;">O</td><td style="border: 1px solid black;">N</td><td style="border: 1px solid black;">D</td> </tr> <tr> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;">92</td><td style="border: 1px solid black;">93</td><td style="border: 1px solid black;">94</td><td style="border: 1px solid black;">95</td><td style="border: 1px solid black;">96</td><td style="border: 1px solid black;">97</td><td style="border: 1px solid black;">98</td><td style="border: 1px solid black;">99</td><td style="border: 1px solid black;">00</td><td style="border: 1px solid black;">01</td><td style="border: 1px solid black;">02</td><td style="border: 1px solid black;">03</td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		92	93	94	95	96	97	98	99	00	01	02	03
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2) Site <input style="width: 100%;" type="text"/> Type <input style="width: 100%;" type="text"/>	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 20px; border: 1px solid black;"></td> <td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">F</td><td style="border: 1px solid black;">M</td><td style="border: 1px solid black;">A</td><td style="border: 1px solid black;">M</td><td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">J</td><td style="border: 1px solid black;">A</td><td style="border: 1px solid black;">S</td><td style="border: 1px solid black;">O</td><td style="border: 1px solid black;">N</td><td style="border: 1px solid black;">D</td> </tr> <tr> <td style="border: 1px solid black;"></td> <td style="border: 1px solid black;">92</td><td style="border: 1px solid black;">93</td><td style="border: 1px solid black;">94</td><td style="border: 1px solid black;">95</td><td style="border: 1px solid black;">96</td><td style="border: 1px solid black;">97</td><td style="border: 1px solid black;">98</td><td style="border: 1px solid black;">99</td><td style="border: 1px solid black;">00</td><td style="border: 1px solid black;">01</td><td style="border: 1px solid black;">02</td><td style="border: 1px solid black;">03</td> </tr> </table>		J	F	M	A	M	J	J	A	S	O	N	D		92	93	94	95	96	97	98	99	00	01	02	03
	J	F	M	A	M	J	J	A	S	O	N	D															
	92	93	94	95	96	97	98	99	00	01	02	03															

c	What was the name and address of the physician who diagnosed the cancer?
1)	Name of hospital/clinic or doctor <input style="width: 100%;" type="text"/> Address <input style="width: 100%;" type="text"/> City <input style="width: 45%;" type="text"/> State <input style="width: 45%;" type="text"/>
2)	Name of hospital/clinic or doctor <input style="width: 100%;" type="text"/> Address <input style="width: 100%;" type="text"/> City <input style="width: 45%;" type="text"/> State <input style="width: 45%;" type="text"/>

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

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

SKIP TO Q 5

B. IF YES: When was your last test?

	J	F	M	A	M	J	J	A	S	O	N	D
	92	93	94	95	96	97	98	99	00	01	02	03

C. Was it positive?

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

SKIP TO Q 6

B. Was the TB in your lungs?

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

SERIAL #

3/8" spine part

6.A. [Since your last visit in (MONTH)] Have you been hospitalized overnight?

- No → **SKIP TO Q 7**
 Yes

How many separate times did you stay overnight as a patient in a hospital [since your visit in (MONTH)]?

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

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

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

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

MO		J	F	M	A	M	J	J	A	S	O	N	D		
DAY		0	10	20	30	0	1	2	3	4	5	6	7	8	9
YEAR		92	93	94	95	96	97	98	99	00	01	02	03		

b. How many nights did you spend in the hospital at that time?

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

NIGHTS

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

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

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

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

MO		J	F	M	A	M	J	J	A	S	O	N	D		
DAY		0	10	20	30	0	1	2	3	4	5	6	7	8	9
YEAR		92	93	94	95	96	97	98	99	00	01	02	03		

b. How many nights did you spend in the hospital at that time?

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

NIGHTS

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

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

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

- No → **SKIP TO Q 7**
 Yes

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

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

- No
 Yes
 Don't know

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

		J	F	M	A	M	J	J	A	S	O	N	D				
		88	89	90	91	92	93	94	95	96	97	98	99	00	01	02	03

Before 1989

8.A. We are now going to ask you about specific conditions that may have been diagnosed in your immediate family. Immediate family includes your biological mother, father, brothers and sisters.

Have any members of your immediate blood-related family ever been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?

- No
 Yes
 Don't know

8.B. Have any members of your immediate family ever suffered from (EACH)?

	NO	YES	DON'T KNOW
1. High Cholesterol/Lipids	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. High Blood Sugar/Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. High Blood Pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Stroke	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Chest Pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Heart Attack Before 60	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Broken Hip Before 60	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. Pancreatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SKIP TO Q 9

SKIP TO Q 9

IF YES: Was it:

a. Skin cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Colon cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Prostate cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Other cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Specify:

9.A. [Since your visit in (MONTH)] Have you had a biopsy? (By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

No Yes

REVIEW RESPONSE TO Q 3, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 10

B. How many times have you had a biopsy [since your last visit in (MONTH)]?

0 1 2 3 4 5 6 7 8 9 TIMES

C. For each biopsy, please tell me:

a	b	c
Where in your body?	What did they say the diagnosis or result of the biopsy was?	Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?
1) Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Name of doctor <input type="text"/> Name of hospital/center/clinic <input type="text"/> <input type="text"/> City State DATE
2) Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Name of doctor <input type="text"/> Name of hospital/center/clinic <input type="text"/> <input type="text"/> City State DATE
3) Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Specify: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	Name of doctor <input type="text"/> Name of hospital/center/clinic <input type="text"/> <input type="text"/> City State DATE

GET MEDICAL RELEASE

SERIAL #

3/8" spine part

10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

A. Shingles (or herpes zoster) NO YES

IF YES: Which month and year (since your last visit) did this episode of shingles (zoster) begin?

	J	F	M	A	M	J	J	A	S	O	N	D
	92	93	94	95	96	97	98	99	00	01	02	03

B. Thrush (yeast in your mouth) NO YES

IF YES: Which month and year (since your last visit) did this episode of thrush begin?

	J	F	M	A	M	J	J	A	S	O	N	D
	92	93	94	95	96	97	98	99	00	01	02	03

C. Infectious mononucleosis NO YES

D. Sinusitis, a sinus infection that requires antibiotics NO YES

E. Bronchitis NO YES

F. Pancreatitis NO YES

G. Prostate Problems NO YES

H. High blood pressure or hypertension NO YES

I. Injury to head with loss of consciousness NO YES

J. Chest pain or angina NO YES

K. Heart attack NO YES

L. Congestive heart failure or CHF NO YES

M. Stroke or CVA NO YES

N. Seizure NO YES

O. Osteoporosis (bone thinning) NO YES

P. Arthritis NO YES

IF YES: Was it: Rheumatoid

Osteoarthritis or degenerative

Other

Specify:

Don't know

Q. Avascular necrosis, osteonecrosis, or had a hip replacement NO YES

R. Kidney disease/Renal failure NO YES

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

Name of hospital/clinic or doctor

Address

City State

Name of hospital/clinic or doctor

Address

City State

S. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis.] NO YES

IF YES: Was it: Hepatitis A or infectious hepatitis

Hepatitis B or serum hepatitis

Hepatitis C

Other

Specify:

Don't know

T. Liver disease NO YES

GET MEDICAL RELEASE

IF YES: Was it: Cirrhosis

Fibrosis

Inflammation

Elevated liver function test/enzyme

Other

Specify:

Don't know

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

Name of hospital/clinic or doctor

Address

City State

NO YES

U. [Since your last visit in (MONTH)] Have you received an injection of pneumococcal vaccine/Pneumovax? NO YES

V. [Since your last visit in (MONTH)] Have you received an injection of hepatitis B vaccine or combination of A and B vaccine (Twinrix)? NO YES

W. Have you ever received an injection of hepatitis A vaccine or combination of A and B vaccine (Twinrix)? NO YES

X. Has a doctor or other medical practitioner ever told you that you had sickle cell anemia? NO YES

Y. [Since your visit in (MONTH)] Have you had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system? NO YES

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

IF YES: What was the diagnosis?

Specify:

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

Z. [Since your last visit in (MONTH)] Have you seen a doctor or other medical practitioner for any (other) conditions or problems in the following areas?

a) Eyes

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

NO YES SKIP TO b

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

b) Ears, Nose, Throat, Mouth

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

NO YES SKIP TO c

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

c) Heart

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

NO YES SKIP TO d

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

d) Lungs

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

NO YES SKIP TO e

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

e) Stomach and Intestines

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

NO YES SKIP TO f

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

f) Bones, Joints or Muscles

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

NO YES SKIP TO g

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

g) Genital and Urinary

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

NO YES SKIP TO h

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

h) Skin

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

NO YES SKIP TO i

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

i) Nervous system

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

NO YES SKIP TO j

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

j) Psychological

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

NO YES SKIP TO k

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

Z. Continued

k) Hormones

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

NO YES

SKIP TO
I

Specify:

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

l) Blood and Fluids

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

NO YES

SKIP TO
m

Specify:

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

m) Allergy and Immune system other than HIV infection

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

NO YES

SKIP TO
n

Specify:

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

n) Other

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

NO YES

SKIP TO
Q11.A

1.

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

2.

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

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

NO YES

- 1) Facial herpes, cold sores, or fever blisters
- 2) Sores in genital region
- 3) Sores in the anal or rectal areas
- 4) Sores elsewhere on your body

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

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

C. Has there been a period [since your last visit in (MONTH)] when your (herpes) sores seemed to come more often, get worse or last longer than usual?

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

DISEASE OR CONDITION	HAD DISEASE	
	NO	YES
A) Syphilis	<input type="radio"/>	<input type="radio"/>
B) Any form of gonorrhea	<input type="radio"/>	<input type="radio"/>
IF "NO" TO (B), SKIP TO (F)		
C) Urethral gonorrhea (clap or drip of the urinary passage)	<input type="radio"/>	<input type="radio"/>
D) Oral gonorrhea (of the mouth or throat)	<input type="radio"/>	<input type="radio"/>
E) Rectal gonorrhea (of the rectum)	<input type="radio"/>	<input type="radio"/>
F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that's not caused by gonorrhea)	<input type="radio"/>	<input type="radio"/>
G) Genital warts or anal warts (condylomata acuminata)	<input type="radio"/>	<input type="radio"/>
H) Chlamydia	<input type="radio"/>	<input type="radio"/>
I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis	<input type="radio"/>	<input type="radio"/>

Specify:

13.A. [Since your visit in (MONTH)] Have you had any of the following problems or symptoms?

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 visit in (MONTH)]?		b Did that last for two weeks or longer?		c And do you have that now?		d Is this a new condition? IF NO, GO TO NEXT ROW		e In what month and year since your last visit did it begin? [IF NEEDED: Even though you don't remember the exact month, it would help if you could tell me the season or approximate time of year when it started (this last time)].
	NO	YES	NO	YES	NO	YES	NO	YES	
1) Persistent dizziness for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	WHEN BEGAN (Month and Year) <input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
7) Diarrhea for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
8) Drenching sweats at night on at least 3 occasions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
9) Nausea, vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
10) Abdominal pain, bloating, cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
11) Ascites (fluid buildup in the stomach or abdomen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
13) An unusual bruise or bump or skin discoloration that lasted at least two weeks	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
15) Anemia, low RBC, low hemoglobin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03
16) Blood in urine	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="checkbox"/> J <input type="checkbox"/> F <input type="checkbox"/> M <input type="checkbox"/> A <input type="checkbox"/> M <input type="checkbox"/> J <input type="checkbox"/> J <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input type="checkbox"/> N <input type="checkbox"/> D 92 93 94 95 96 97 98 99 00 01 02 03

3/8" spine part

SERIAL #

13.A. Continued

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	a		b		c		d		e In what month and year since your last visit did it begin? [IF NEEDED: Even though you don't remember the exact month, it would help if you could tell me the season or approximate time of year when it started (this last time)].
	NO	YES	NO	YES	NO	YES	NO	YES	
17) Unusual bleeding or bleeding that is difficult to stop	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	WHEN BEGAN (Month and Year) J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
18) Muscle pain or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
19) Joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
20) Painful urination	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
21) Kidney stones	<input type="radio"/>	<input type="radio"/>			<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
22) High blood sugar, diabetes (We mean a new diagnosis or an uncontrolled condition.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
23) High cholesterol, high triglycerides or high lipids (We mean a new diagnosis or an uncontrolled condition.)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
24) Fat maldistribution or abnormal changes in body fat	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
25) Vivid nightmares or dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03
26) Insomnia or problems sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	J F M A M J J A S O N D 92 93 94 95 96 97 98 99 00 01 02 03

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

- Pain, aching, or burning in your feet or legs?
- Pins and needles in your feet or legs?
- Numbness (lack of feeling) in your feet or legs?

If NO, go to next question. If YES, indicate severity.	
NO	YES
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>
<input type="radio"/>	<input type="radio"/>

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

Right	0	1	2	3	4	5	6	7	8	9	10
Left	0	1	2	3	4	5	6	7	8	9	10
Right	0	1	2	3	4	5	6	7	8	9	10
Left	0	1	2	3	4	5	6	7	8	9	10
Right	0	1	2	3	4	5	6	7	8	9	10
Left	0	1	2	3	4	5	6	7	8	9	10

14. A. [Since your visit in (MONTH)] Has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs?

- No → **SKIP TO Q 15**
 Yes

B. What type of test was done?

	NO	YES	DON'T KNOW
1) Phenotype	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2) Genotype	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

15. Since your last visit, have you taken any HIV-related medications or treatments? (That is, medications or treatments to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS excluding acyclovir.)

- No
 Yes → **SKIP TO Q 15.B (1)**

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

READ EACH, MARK ALL THAT APPLY

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

Specify: _____

SKIP TO Q 16

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

- No
 Yes → **SKIP TO Q 15.B (3)**

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

READ EACH, MARK ALL THAT APPLY

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

Specify: _____

SERIAL #

SKIP TO Q 15.C

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

FILL IN THE BUBBLE NEXT TO THE DRUG(S).

- 3-TC (Eпивir, Lamivudine)
 Abacavir (Ziagen)
 Amprenavir (Agenerase)
 AZT (Retrovir, Zidovudine)
 Atazanavir (BMS-232632)
 Combivir (AZT & 3-TC)
 d4T (Zerit, Stavudine)
 ddC (dideoxycytidine, HIVID, Zalcitabine)
 ddI (dideoxyinosine, Didanosine, Videx)
 Delavirdine (Rescriptor)
 Efavirenz (Sustiva)
 Indinavir (Crixivan)
 Lopinavir/r (Kaletra)
 Nelfinavir (Viracept)
 Nevirapine (Viramune)
 Ritonavir (Norvir)
 Saquinavir (Invirase, Fortovase)
 Tenofovir (Viread)
 Trizivir (abacavir + zidovudine + lamivudine)
 T-20
 Other anti-viral from Drug List 1 → (Report Acyclovir in Q16.)

1. _____

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

2. _____

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

3. _____

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

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

- No → **SKIP TO Q 15.C**
 Yes

IF YES: How many times did this occur?

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

Did your physician prescribe or agree to any of these?

- No Yes

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

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

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B(3)

15.C. (1) [Since your last visit in (MONTH)] Have you taken any medication or drug on this list [SHOW LIST 2] to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- No → **SKIP TO Q 15.D**
 Yes

(2) Please name those drugs that you have taken. (FILL IN THE BUBBLE NEXT TO THE DRUG(S). FOR DRUGS NOT ON THE LIST, RECORD THE NAME UNDER "OTHER" AS STATED BY THE PARTICIPANT.)

- | | |
|--|---|
| <input type="radio"/> Atovaquone (BW566C80, Mepron) | <input type="radio"/> Hydroxyurea (Hydrea) |
| <input type="radio"/> Azithromycin (Zithromax) | <input type="radio"/> Interleukin-2 (IL-2) |
| <input type="radio"/> Bactrim (Septra, SMZ-TMP, Sulfamethoxazole) | <input type="radio"/> Itraconazole (Sporonox) |
| <input type="radio"/> Ciprofloxacin (CIPRO) | <input type="radio"/> Ketoconazole (Nizoral) |
| <input type="radio"/> Clarithromycin (Biaxin) | <input type="radio"/> Megace |
| <input type="radio"/> Co-enzyme Q | <input type="radio"/> Mycelex (clotrimazole) |
| <input type="radio"/> Colony stimulating factors (GM-CSF, G-CSF, Neupogen) | <input type="radio"/> NAC (N-acetyl-cysteine) |
| <input type="radio"/> Cortisone | <input type="radio"/> Nandrolone (Deca-Durabolin) |
| <input type="radio"/> Dapsone | <input type="radio"/> Nystatin (Mycostatin) |
| <input type="radio"/> DHEA | <input type="radio"/> Oxandrin (Oxandrolone) |
| <input type="radio"/> Ethambutol (Myambutol) | <input type="radio"/> Pentamidine (aerosolized) |
| <input type="radio"/> Erythropoietin (Epogen, Procrit) | <input type="radio"/> Rifabutin (Ansamycin, Mycobutin) |
| <input type="radio"/> Flagyl (metronidazole) | <input type="radio"/> Serostim |
| <input type="radio"/> Fluconazole (Diflucan) | <input type="radio"/> Testosterone (Delatestryl, Virilon, Testoderm, Androderm, AndroGel) |
| <input type="radio"/> Ganciclovir (DHPG, Cytovene) | <input type="radio"/> Vaccine trial (generic) |

Other from Drug List 2 (Report Acyclovir in Q16.)

1.

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

COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q 15.C(1)

D. (1) [Since your last visit in (MONTH)] Have you taken any medication, drug or other therapy that was not listed to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- No → **SKIP TO Q 16**
 Yes

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

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16. Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include either prescribed drugs or other things you took on your own [since your visit in (MONTH)].

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a)	a How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?																																	
IF "NO" TO a GO TO NEXT ITEM	NO YES																																		
1) Steroids that you took by mouth or were injected	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____																																	
2) Thyroid hormone or medication	<input type="radio"/> NO <input type="radio"/> YES	Name: _____																																	
3) Other hormones such as anabolic steroids	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____																																	
4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____																																	
5) Medication taken by mouth for fungal infection	<input type="radio"/> NO <input type="radio"/> YES	Name: _____																																	
6) Medication taken by mouth for worms or parasites	<input type="radio"/> NO <input type="radio"/> YES	Name: _____																																	
7) Tranquilizers or sleeping pills IF YES, have you taken/used any in the last 7 days? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ Used for: _____																																	
8) Antidepressants or mood elevators	<input type="radio"/> NO <input type="radio"/> YES	Name: _____ _____																																	
9) Lithium	<input type="radio"/> NO <input type="radio"/> YES	Used for: _____																																	
10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, was this for: chronic herpes? <input type="radio"/> No <input type="radio"/> Yes episodic herpes? <input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> NO <input type="radio"/> YES	Name: _____																																	
11) Viagra	<input type="radio"/> NO <input type="radio"/> YES	Used for: _____																																	
12) Cholesterol, triglycerides or lipid lowering medications a. (SPECIFY in column b) _____ <table border="1" data-bbox="277 1346 662 1440"> <tr><td> </td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 16.13	Name: _____
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b. (SPECIFY in column b) _____ <table border="1" data-bbox="277 1503 662 1598"> <tr><td> </td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 16.13	Name: _____
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13) Medications used for diabetes a. (SPECIFY in column b) _____ <table border="1" data-bbox="277 1818 662 1913"> <tr><td> </td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td> </td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td> </td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<input type="radio"/> NO <input type="radio"/> YES SKIP TO Q 16.14	Name: _____
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SERIAL #

16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 15a)	a How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?																																	
IF "NO" TO a GO TO NEXT ITEM																																			
<p>13) Medications used for diabetes (cont.)</p> <p>b. (SPECIFY in column b)</p> <table border="1" data-bbox="196 331 581 430"> <tr><td><input type="checkbox"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	<p>NO YES</p> <p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 16.14</p>	<p>Name:</p>
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<p>c. (SPECIFY in column b)</p> <table border="1" data-bbox="196 493 581 592"> <tr><td><input type="checkbox"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	<p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 16.14</p>	<p>Name:</p>
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<p>14) Hepatitis medications</p> <p>a. (SPECIFY in column b)</p> <table border="1" data-bbox="196 682 581 781"> <tr><td><input type="checkbox"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="checkbox"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900	<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90	<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	<p><input type="radio"/> <input type="radio"/></p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>
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17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?

No SKIP TO Q 18 Yes

B. Do you know the name of the trial?

No Yes →

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
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C. Where did you go for this trial?

Name of hospital or clinic

Address

City State

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

18.A. Since your last visit did you have [ASK EACH ITEM AND RECORD ANSWER]

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

Specify:

0
1
2
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18.B. Do you have insurance coverage that pays for any of your medications? NO YES

IF NO TO Q 18.A (1)–(9) AND Q 18.B, THEN SKIP TO Q 22

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

NO YES

→ SKIP TO Q 21

B. If YES, was that change your choice?

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

	NO	YES
1) Lost or quit job	<input type="radio"/>	<input type="radio"/>
2) Changed job (employer or employment status)	<input type="radio"/>	<input type="radio"/>
3) Employer changed or dropped coverage	<input type="radio"/>	<input type="radio"/>
4) Pre-existing medical condition limited choices	<input type="radio"/>	<input type="radio"/>
5) To be able to choose doctors or providers	<input type="radio"/>	<input type="radio"/>
6) More or better coverage of needed or desired services	<input type="radio"/>	<input type="radio"/>
7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed	<input type="radio"/>	<input type="radio"/>
8) Financial reasons (cost of premiums, co-payments or deductibles)	<input type="radio"/>	<input type="radio"/>
9) Eligible for Medicare	<input type="radio"/>	<input type="radio"/>

D. [IF "YES" TO MORE THAN ONE RESPONSE IN Q 19.C, ASK] Which one was the PRIMARY reason? [READ ALL CHOICES AND SELECT ONLY ONE]

- Lost or quit job
- Changed job (employer or employment status)
- Employer changed or dropped coverage
- Pre-existing medical condition limited choices
- To be able to choose doctors or providers
- More or better coverage of needed or desired services
- Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed
- Financial reasons (cost of premiums, co-payments or deductibles)
- Eligible for Medicare

3/8" spine part

19.E. Are you currently insured?

- No → **SKIP TO Q 22**
 Yes

20.A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)

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

B. [IF "YES" TO MORE THAN ONE RESPONSE IN Q20.A, ASK] What was the PRIMARY reason for choosing your current medical coverage? [READ ALL CHOICES AND SELECT ONE]

- Employer offers only one plan
- Only eligible for current coverage due to medical condition
- To be able to choose doctors or providers
- To have more or better coverage of needed or desired services
- Eligible for Medicaid, Medi-Cal, or Medical Assistance
- Financial reasons (cost of premiums, co-payments or deductibles)
- Eligible for Medicare

21. All things considered, how satisfied are you with your current health insurance plan? [SHOW CARD TO PARTICIPANT OR READ ALOUD]

- 1) Completely satisfied, couldn't be better
- 2) Very satisfied
- 3) Somewhat satisfied
- 4) Neither satisfied nor dissatisfied
- 5) Somewhat dissatisfied
- 6) Very dissatisfied
- 7) Completely dissatisfied, couldn't be worse

22. Did you have any type of dental insurance coverage at any time since your last visit in (MONTH)?

- No
- Yes

23. Where do you usually go for medical care, even if you haven't received medical care since your last visit?

[READ ALL CHOICES AND SELECT ONLY ONE]

- HMO
- Doctor's office or specialty clinic (non-HMO) including Urgent Care
- Any other clinic
- Emergency room
- Other outpatient

Specify:

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

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

SERVICE	a		b	
	Have you used (EACH) since your last visit?		How many times? (99 = 99 or more)	
1) HMO	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9
3) Any other clinic	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9
4) Emergency room	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9
5) Other outpatient	NO <input type="radio"/>	YES <input type="radio"/>	<input type="text"/>	<input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9

Specify:

SERIAL #

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

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

26. Please estimate the **TOTAL** out-of-pocket expenses that you or other personal sources (your lover, family or friends) paid for prescription medications since your last visit in (MONTH). [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN \$1]

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

OR
 Don't know
 Refused

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

No → **SKIP TO Q 28**
 Yes ↓

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

1) Medical care

No → **SKIP TO (2)**
 Yes → Why did you not seek medical care?
[READ EACH AND MARK ALL THAT APPLY]
 Financial reasons
 Other non-financial reasons

Specify:

2) Dental care

No → **SKIP TO (3)**
 Yes → Why did you not seek dental care?
[READ EACH AND MARK ALL THAT APPLY]
 Financial reasons
 Other non-financial reasons

Specify:

3) Prescription Medications

No → **SKIP TO Q 28**
 Yes → Why did you not obtain prescription medications?
[READ EACH AND MARK ALL THAT APPLY]
 Financial reasons
 Other non-financial reasons

Specify:

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

No
 Yes

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

No
 Yes

ACASI begins here. Skip to last page, Q 50.A.

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

- Less than \$10,000
- 10,000–19,999
- 20,000–29,999
- 30,000–39,999
- 40,000–49,999
- 50,000–59,999
- 60,000 or more
- Does not wish to answer

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

No → **SKIP TO Q 32**
 Yes

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

- Less
- Same
- Greater

32. Since your last visit, has your employment status changed for any reason related to HIV disease?

No → **SKIP TO Q 33**
 Yes

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

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

Specify:

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

33. Now I have some questions about cigarette smoking.

A. Have you ever smoked cigarettes?

- No → **SKIP TO Q 34**
 Yes

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

- No → **SKIP TO Q 34**
 Yes
 Occasionally (less than one cigarette per day)
 ↓ **SKIP TO Q 34**

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

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

34. The next questions are about alcoholic beverages—that is, wine, beer or liquor you've drunk [since your visit in (MONTH)].

A. Did you drink any alcoholic beverages [since your visit in (MONTH)]?

- No → **SKIP TO Q 35**
 Yes

34.B. How often do you have a drink containing alcohol (a glass of beer, wine, a mixed drink, any kind of alcoholic beverage)?

- At least once a day 2 or 3 times a month
 Nearly every day About once a month
 3 to 4 times a week 6–11 times a year
 Once or twice a week 1–5 times a year

C. [Since your visit in (MONTH)] On days when you drank any alcoholic beverages, how many drinks did you USUALLY have altogether? (By a drink we mean a can or glass of beer, a 4-ounce glass of wine, a 1 1/2-ounce shot of liquor, or a mixed drink with that amount of liquor.) Please turn to page 2 in your booklet for the possible answers to this.

- 1 or 2 drinks 5 or 6 drinks
 3 or 4 drinks 7 or more drinks

D. Have you ever been in an alcohol treatment program, including inpatient and/or outpatient detox, alcoholics anonymous, and/or any other program?

- No
 Yes

READ DEFINITION OF SEXUAL ACTIVITY:

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

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

- No → **SKIP TO Q 42**
 Yes

36. Have you had any sexual activity with a woman since your last visit?

- No → **SKIP TO Q 39**
 Yes

37. Now lets talk about how many different women you have had sexual activity with since your last visit.

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

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

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

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

3/8" spine part

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

IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 38.10

38. IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

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

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SERIAL #

38. Continued

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

No → **SKIP TO Q 42**
 Yes
 ↓

40. Now lets talk about how many different men you have had sexual activity with since your last visit.

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

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

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

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

The next questions are about different kinds of sexual activity some men engage in with other men.
IF NO INTERCOURSE WITH MEN, SKIP TO Q 41.13

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit? NO YES <input type="radio"/> <input type="radio"/>	b How many men did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What's your best estimate?) 0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
<p>41. IF ONLY ONE PARTNER: USE COLUMN a. IF MULTIPLE PARTNERS: USE COLUMN b.</p> <p>1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (4).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>
<p>IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>
<p>IF MULTIPLE PARTNERS: 3) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>

<p>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>
<p>IF MULTIPLE PARTNERS: 5) Thinking of the times you put your penis in their anus/butt, with how many men did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times you put your penis in his anus/butt, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>
<p>IF MULTIPLE PARTNERS: 6) With how many men did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>

3/8" spine
perf

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SERIAL #

41. Continued

IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

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

<p>10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<input type="text"/>	0	1	2	3	4	5	6	7	8	9																									
<p>IF MULTIPLE PARTNERS: 11) Thinking of the times when a man put his penis in your anus/butt, with how many men was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Thinking of the times he put his penis in your anus/butt, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<input type="text"/>	0	1	2	3	4	5	6	7	8	9																									
<p>IF MULTIPLE PARTNERS: 12) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<input type="text"/>	0	1	2	3	4	5	6	7	8	9																									

<p>13) You used your tongue to touch or lick his anus/butt ("rimming").</p>	<p>NO YES <input type="radio"/> <input type="radio"/></p>	<table border="1"> <tr><td><input type="text"/></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td><input type="text"/></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td><input type="text"/></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>	<input type="text"/>	0	100	200	300	400	500	600	700	800	900	<input type="text"/>	0	10	20	30	40	50	60	70	80	90	<input type="text"/>	0	1	2	3	4	5	6	7	8	9
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<input type="text"/>	0	1	2	3	4	5	6	7	8	9																									

3/8" spine part

42. Now let's talk about other drugs you may have used. As I read each one, please tell me whether you used it even once [since your visit in (MONTH)]?

	a How about (EACH) Have you (taken/used) any [since your visit in (MONTH)]?		b How often did you (use/take) (DRUG) [since your visit in (MONTH)]?			
	NO <input type="radio"/>	YES <input type="radio"/>	DAILY	WEEKLY	MONTHLY	LESS OFTEN
Pot, Marijuana or Hash	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Crack or cocaine that you smoke	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other forms of cocaine	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speed, Meth or Ice	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heroin	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Speedball (heroin and cocaine together)	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ecstasy, XTC, X or MDMA	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Other kinds of street/club drugs	NO <input type="radio"/>	YES <input type="radio"/>	<input type="radio"/> <input type="radio"/> <input type="radio"/> <input type="radio"/>			
Specify:	<input type="radio"/>	<input type="radio"/>				
Specify:	<input type="radio"/>	<input type="radio"/>				
Specify:	<input type="radio"/>	<input type="radio"/>				
Specify:	<input type="radio"/>	<input type="radio"/>				
Specify:	<input type="radio"/>	<input type="radio"/>				
Specify:	<input type="radio"/>	<input type="radio"/>				

3/8" spine
perforated

203770-317

SERIAL #

43. A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?

No → **SKIP TO Q 49**
 Yes

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

No
 Yes

C. Do you currently inject drugs?

No
 Yes

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

Speedball (cocaine and heroin together)

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

Cocaine by itself

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

Heroin by itself

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

Speed by itself

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

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

No → **SKIP TO Q 46**
 Yes

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

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

B. With how many different people?

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

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

No → **SKIP TO Q 47**
 Yes

B. How many times?

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

C. With how many different people?

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

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

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

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

No → **SKIP TO Q 49**
 Yes

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

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

C. Do you have another source of clean needles?

No
 Yes

49. [Since your last visit in (MONTH)] have you been in a drug treatment program, including inpatient and/or outpatient detox, methadone maintenance programs, halfway houses, narcotics anonymous, prison or jail-based programs and/or any other program?

No
 Yes

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

- No, nothing more
- Yes

THANK PARTICIPANT AND SKIP TO Q 51

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

Handwritten notes in the response area for question 50.B:

1. I have a 10 year old son who is in the military and is deployed to Afghanistan. I am worried about him and his safety. I have been thinking about him a lot and wondering if he is safe. I have been talking to him on the phone and he seems to be doing well. I am glad to hear that he is safe and healthy. I have been thinking about him a lot and wondering if he is safe. I have been talking to him on the phone and he seems to be doing well. I am glad to hear that he is safe and healthy.

51. ACASI interview?

- No
- Yes

52. Telephone interview?

- No
- Yes

53. Home visit?

- No
- Yes

54. PWA interview?

- No
- Yes
- Don't know

55. Returning censored participant?

- No
- Yes

56.

Date interview completed

TIME ENDED			
HR	MIN		
0	0	0	0
10	1	10	1
	2	20	2
	3	30	3
	4	40	4
	5	50	5
	6		6
	7		7
	8		8
	9		9

AM

PM

57.

Interviewer's signature

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

3/8" spine
perft





SERIAL #

