

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

- No
 Yes

IF "NO," GO TO Q 3

AID_52

a IF YES: What was the diagnosis? (SEE APPENDIX 7 IN GUIDELINES FOR LIST OF AIDS DIAGNOSES.)	b In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?																																																																			
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c What was the name and address of the physician who diagnosed the condition(s)?

 Name of hospital/clinic or doctor

 Address

 City State

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 Name of hospital/clinic or doctor

 Address

 City State

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

- No
 Yes

IF "NO," GO TO Q 4

PNEUM_52

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

J	F	MPNEU_52						S	O	N	D
99	00	PNEUY_52						07	08	09	10

Clinician's Notes: Method of Diagnosis

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

 Name of hospital/clinic or doctor

 Address

 City State

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

* 4.A. Since your last visit [in (MONTH, YEAR)], did you have a skin test for TB, sometimes called a PPD? NO YES
PPDV_52 SKIP TO Q 5

B. IF YES: When was your last test?

	J	F	M	PPDM_52	A	S	O	N	D
	99	00	06	PPDY_52	16	07	08	09	10

NO YES
C. Was it positive? PSPPD_52

* 5.A. Since your last visit [in (MONTH, YEAR)] have you had an active TB infection? TBDXE_52
SKIP TO Q 6
B. Was the TB in your lungs? TBILG_52
C. Was the TB in any other part of your body (other than your lungs)? TBOLG_52

* 6.A. Since your last visit [in (MONTH, YEAR)], have you been admitted to the hospital for any reason? This includes overnight stays and outpatient procedures.
 No SKIP TO Q 7 HOSP_52
 Yes How many separate times were you a patient in a hospital since your last visit [in (MONTH, YEAR)]?

	0	10	70	80	90					
	0	1	2	3	4	5	6	7	8	9

NHOSP_52

GET MEDICAL RELEASE

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

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

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

MO		J	F	HOS1M_52	S	O	N	D
DAY		0	10	HOS1D_52				
		0	1		8	9		
YEAR		99	00	HOS1Y_52	07	08	09	10

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

	0	10	20	80	90					
	0	1	2	3	4	5	6	7	8	9

HOS1N_52 NIGHTS

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

<p>What was the name and address of the physician who diagnosed the condition(s)? IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE</p> <p>Name of hospital/clinic or doctor _____</p> <p>Address _____</p> <p>City _____ State _____</p>	<table style="width: 100%;"> <tr> <td style="width: 60%; border: 1px solid black; height: 60px; vertical-align: top;">1) Diagnosis or procedure</td> <td style="width: 40%; border: 1px solid black;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">V</td> <td style="text-align: center;">E</td> <td style="text-align: center;">P</td> <td style="text-align: right;">TYHO11_52</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1M</td> <td style="text-align: center;">2M</td> <td style="text-align: center;">3M</td> <td style="text-align: center;">4M</td> <td style="text-align: center;">5M</td> <td style="text-align: center;">6M</td> <td style="text-align: center;">7M</td> <td style="text-align: center;">8M</td> <td style="text-align: center;">9M</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">10</td> <td style="text-align: center;">20</td> <td style="text-align: center;">30</td> <td style="text-align: center;">40</td> <td style="text-align: center;">50</td> <td style="text-align: center;">60</td> <td style="text-align: center;">70</td> <td style="text-align: center;">80</td> <td style="text-align: center;">90</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> </tr> </table> </td> </tr> <tr> <td style="border: 1px solid black; 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2) Diagnosis or procedure	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="text-align: center;">V</td> <td style="text-align: center;">E</td> <td style="text-align: center;">P</td> <td style="text-align: right;">TYHO12_52</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1M</td> <td style="text-align: center;">2M</td> <td style="text-align: center;">3M</td> <td style="text-align: center;">4M</td> <td style="text-align: center;">5M</td> <td style="text-align: center;">6M</td> <td style="text-align: center;">7M</td> <td style="text-align: center;">8M</td> <td style="text-align: center;">9M</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">10</td> <td style="text-align: center;">20</td> <td style="text-align: center;">30</td> <td style="text-align: center;">40</td> <td style="text-align: center;">50</td> <td style="text-align: center;">60</td> <td style="text-align: center;">70</td> <td style="text-align: center;">80</td> <td style="text-align: center;">90</td> </tr> <tr> <td style="text-align: center;">0</td> <td style="text-align: center;">1</td> <td style="text-align: center;">2</td> <td style="text-align: center;">3</td> <td style="text-align: center;">4</td> <td style="text-align: center;">5</td> <td style="text-align: center;">6</td> <td style="text-align: center;">7</td> <td style="text-align: center;">8</td> <td style="text-align: center;">9</td> </tr> </table>	V	E	P	TYHO12_52	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	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																																																																

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

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

MO		J	F	HOS2M_52	S	O	N	D					
DAY		0	10	HOS2D_52									
YEAR		0	1	HOS2Y_52	8	9							
		99	00	01	02	03	04	05	06	07	08	09	10

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

	0	10	HOS2N_52	70	80	90				
	0	1	2	3	4	5	6	7	8	9

NIGHTS

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

RECORD FULLY IN R's OWN WORDS.

<p>What was the name and address of the physician who diagnosed the condition(s)? IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE</p> <p>Name of hospital/clinic or doctor</p> <p>Address</p> <p>City State</p>	<p>1) Diagnosis or procedure</p>	<p>V E P TYHO21_52</p> <p>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</p> <p>0 100 H2DX1_52 700 800 900</p> <p>0 10 20 30 40 50 60 70 80 90</p> <p>0 1 2 3 4 5 6 7 8 9</p>
	<p>2) Diagnosis or procedure</p>	<p>V E P TYHO22_52</p> <p>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</p> <p>0 100 H2DX2_52 700 800 900</p> <p>0 10 20 30 40 50 60 70 80 90</p> <p>0 1 2 3 4 5 6 7 8 9</p>

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

No → **SKIP TO Q 7** PHOS2_52

Yes

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

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

No DEPR_52

Yes

Don't know

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

	J	F	M	DEPRM_52	S	O	N	D
	99	00	01	DEPRY_52	07	08	09	10

7.B. Since your last visit [in (MONTH, YEAR)], have you had any neurological evaluation or a physical examination to look for problems of the nervous system (brain, spinal cord, nerves in hands and feet)?

No NRLEX_52

Yes

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.

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

	NO	YES	DON'T KNOW
a. high blood pressure or hypertension?	<input type="radio"/>	<input type="radio"/> HYPTR_52	<input type="radio"/>
b. angina, which often causes chest pain?	<input type="radio"/>	<input type="radio"/> CPHDR_52	<input type="radio"/>
c. a heart attack or myocardial infarction (MI) before age 55?	<input type="radio"/>	<input type="radio"/> HRATR_52	<input type="radio"/>
d. congestive heart failure or CHF?	<input type="radio"/>	<input type="radio"/> CHFR_52	<input type="radio"/>
e. a stroke or CVA?	<input type="radio"/>	<input type="radio"/> STROR_52	<input type="radio"/>
f. mini-strokes or transient ischemic attacks (TIA)?	<input type="radio"/>	<input type="radio"/> TIAR_52	<input type="radio"/>
g. high cholesterol, high triglycerides, high lipids or too much fat in their blood?	<input type="radio"/>	<input type="radio"/> HYPER_52	<input type="radio"/>
h. high blood sugar or diabetes?	<input type="radio"/>	<input type="radio"/> DIABR_52	<input type="radio"/>

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

No Yes Don't Know → **SKIP TO Q 9.A.(1)** **CANCR_52**
 No → **SKIP TO Q 9.A.(1)**

IF YES: Was it:

	NO	YES	DON'T KNOW
a. Skin cancer	<input type="radio"/>	<input type="radio"/> SCANR_52	<input type="radio"/>
b. Colon cancer	<input type="radio"/>	<input type="radio"/> CCANR_52	<input type="radio"/>
c. Prostate cancer	<input type="radio"/>	<input type="radio"/> PCANR_52	<input type="radio"/>
d. Cervical cancer (female family members)	<input type="radio"/>	<input type="radio"/> VCANR_52	<input type="radio"/>
e. Anal cancer	<input type="radio"/>	<input type="radio"/> ACANR_52	<input type="radio"/>
f. Other cancer	<input type="radio"/>	<input type="radio"/> OCANR_52	<input type="radio"/>

Specify:

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

No → **GO TO Q 9.B** **APAPS_52**
 Yes
 Don't Know → **GO TO Q 9.B**

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

<input type="text"/>	J	F	M	PAPSM_52	S	O	N	D
<input type="text"/>	99	00	01	PAPSY_52	07	08	09	10

(3) Were the results abnormal?

No → **GO TO Q 9.B**
 Yes → **GET MEDICAL RELEASE** **ABRAP_52**
 Unable to evaluate/don't know → **GET MEDICAL RELEASE**

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

Name of doctor _____

Name of hospital/center/clinic _____

City _____ State _____

SERIAL #

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

- No
- Yes
- Don't Know

ANOSC_52

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

- No
- Yes

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

BIOPS_52

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

BIOP_52 TIMES

(3) For each biopsy, please tell me:

a Where in your body?	b What did they say the diagnosis or result of the biopsy was?	c Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy.
<p>1) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> BIOP1_52 <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> BIDX1_52 <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>_____</p> <p>City State DATE</p>
<p>2) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> <input type="text" value="20"/> <input type="text" value="30"/> <input type="text" value="40"/> <input type="text" value="50"/> <input type="text" value="60"/> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> BIOP2_52 <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> BIDX2_52 <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>_____</p> <p>City State DATE</p>
<p>3) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> <input type="text" value="20"/> <input type="text" value="30"/> <input type="text" value="40"/> <input type="text" value="50"/> <input type="text" value="60"/> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> BIOP3_52 <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> BIDX3_52 <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>_____</p> <p>City State DATE</p>

GET MEDICAL RELEASE

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

NO YES

- A. Shingles HERPZ_52
- B. Thrush (yeast in your mouth) THRSH_52
- C. Sinusitis, a sinus infection that requires antibiotics SINUS_52
- D. Bronchitis BRONC_52
- E. Pancreatitis PANCS_52
- F. Prostate problems (not cancer) PROST_52
- G. Erectile dysfunction (erectile problems) ERDYS_52
- H. High blood pressure or hypertension HBPHT_52
- I. Anemia, low RBC, low hemoglobin ANEMA_52
- J. High cholesterol, high triglycerides, high lipids or too much fat in your blood HCHOL_52
- K. High blood sugar or diabetes HBSUG_52
- L. Arthritis ARTHR_52
 IF YES: Was it: Rheumatoid RHEUM_52
 (Read and answer each.) Osteoarthritis or degenerative OSTAR_52
Other OTHAR_52

Specify:

Don't know

DKWAR_52

- *M. Angina or chest pain caused by your heart ANGIN_52
- *N. Heart attack or myocardial infarction (MI) HRTAT_52
- *O. Congestive heart failure or CHF HRTFA_52
- *P. Stroke or Cerebrovascular accident (CVA) STROK_52
- *Q. Mini-strokes or transient ischemic attacks (TIA) TIA_52
- *R. Too fast, too slow, or irregular heart beat IRHB_52
- *S. Any blood vessels (arteries) that were blocked or closed BVES_52
 IF NO, SKIP TO Q U
- *T. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas OBVES_52
- *U. A blood clot in your legs BCLG_52
- *V. A blood clot in your lungs BCLN_52
- *W. Seizure or convulsions SEZUR_52
- *X. Osteoporosis (bone thinning) OSTEO_52
- *Y. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis HIPNE_52
- *Z. Kidney disease/Renal failure KIDND_52
- AA. An elevated liver enzyme LIVDE_52
- BB.1 Broken or fractured bone(s)? BBONE_52
 IF NO, SKIP TO Q CC

BB.2 What was fractured?

See Appendix 9 in guidelines for list of fracture site codes.

Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	100	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

BBSITE1_52

Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	100	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

BBSITE2_52

Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	100	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

BBSITE3_52

BB.3 Did that fracture occur . . .

BBHOW_52 Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)

As a result of a fall from standing height or less (includes falls due to slipping or tripping)

Because of a harder fall (example, falling down steps)

From a car accident or other severe external force

Don't know

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

Name of hospital/clinic or doctor

Address

City

State

DX

Date of diagnosis

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

Name of hospital/clinic or doctor

Address

City

State

DX

Date of diagnosis

SERIAL #

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

a) Eyes

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

NO YES
VIDY_52
EYDIA_52

SKIP TO b

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	EYCON_52						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 and Sinuses

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

NO YES
VIDEN_52
ENDIA_52

SKIP TO c

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	ENCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

c) Heart and Blood Vessels

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

NO YES
VIDHT_52

GET MEDICAL RELEASE →

SKIP TO d

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	HTCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

d) Lungs and Bronchial Tubes

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

NO YES
VIDLG_52
LG DIA_52

SKIP TO e

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	LGCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

e) Stomach, Intestines, or Liver Disease

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

NO YES
VIDSL_52
SLDIA_52

SKIP TO f

IF LIVER DISEASE, GET MEDICAL RELEASE

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	SLCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

f) Joints or Muscles

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

NO YES
VIDJM_52
JMDIA_52

SKIP TO g

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	JMCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

g) Genital, Urinary and Rectal

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

NO YES
VIDGU_52
GUDIA_52

SKIP TO h

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	GUCON_52						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
VIDSK_52
SKDIA_42

SKIP TO i

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	SKCON_52						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
VIDNS_52

GET MEDICAL RELEASE →

NSDIA_52

SKIP TO j

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	NSCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

j) Treatment of depression, anxiety or other mental health problems

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

NO YES
VIDPY_52
PYDIA_52

SKIP TO k

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
0	100	200	PYCON_52						800	900
0	10	20	30	40	50	60	70	80	90	
0	1	2	3	4	5	6	7	8	9	

CC. Continued

k) Hormones or Endocrine system

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDHO_52
HODIA_52

SKIP TO I

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	20	HOCON_52	30	600	900			
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

l) Blood

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDBF_52

GET MEDICAL RELEASE

BFDIS_52

SKIP TO m

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	20	BFCON_52	300	600	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
VIDAI_52
AIDIA_52

SKIP TO n

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	20	AICON_52	30	600	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
VIDO_52
ODIA_52

SKIP TO Q11.A

1.

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	20	OCON1_52	30	600	900			
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

2.

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	20	OCON2_52	30	600	900			
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

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

Name of hospital/clinic or doctor

Address

City

State

11.A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, since your last visit [in (MONTH, YEAR)]? NO YES

- 1) Facial herpes, cold sores, or fever blisters **HERPF_52**
- 2) Sores in genital region **HERPG_52**
- 3) Sores in the anal or rectal areas **HERPA_52**
- 4) Sores elsewhere on your body **HERPE_52**

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

B. Did the first attack of herpes you ever had occur since your last visit [in (MONTH, YEAR)]? **HERLV_52**

C. Has there been a period since your last visit [in (MONTH, YEAR)] when your (herpes) sores seemed to come more often, get worse or last longer than usual? **HERWR_52**

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

DISEASE OR CONDITION	HAD DISEASE
	NO YES

A.1) Syphilis **SYPHA_52**

IF "NO," SKIP TO (B)

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

- New infection **SYPHN_52**
- Continued or relapse

B) Any form of gonorrhea **GONOR_52**

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

C) Urethral gonorrhea (clap or drip of the urinary passage) **UGONA_52**

D) Oral gonorrhea (of the mouth or throat) **OGONA_52**

E) Rectal gonorrhea (of the rectum) **RGONA_52**

F) Non-specific or nongonococcal urethritis or chlamydia (that is, a discharge from the penis that's not caused by gonorrhea) **URETC_52**

G.1) Genital warts (condylomata acuminata) **WARTG_52**

IF "NO," SKIP TO (H)

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

- New infection **WRTGN_52**
- Continued or relapse

H.1) Anal warts (condylomata acuminata) **WARTS_52**

IF "NO," SKIP TO (I)

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

- New infection **WRTSN_52**
- Continued or relapse

I) Any other diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis **PARAA_52**

Specify:

SERIAL #

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

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	a		b		c		d			e		
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES	
1) Persistent dizziness for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7) Diarrhea for at least 3 consecutive days	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8) Drenching sweats at night on at least 3 occasions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9) Nausea, vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10) Abdominal pain, bloating, cramps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11) Ascites (fluid buildup in the stomach or abdomen)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13) An unusual bump or skin discoloration that lasted at least two weeks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15) Unusual bleeding or bleeding that is difficult to stop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

13.A. Continued

PROBLEM OR SYMPTOM FOR EACH "YES" IN a, ASK b, c, d, AND e.	a		b		c		d			e	
	How about (EACH)? Did you have that at any time since your last visit [in (MONTH, YEAR)]?		Did that last for two weeks or longer?		And do you have that now?		Did you experience this symptom due to taking any medication?			Is this a new condition?	
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES
16) Muscle pain or weakness	MPAIN_52		MPW2W_52		MPWNO_52		MPMED_52			MPWNC_52	
17) Joint pain	JOINT_52		JNT2W_52		JNTNO_52		JTMED_52			JNTNC_52	
18) Painful urination	PURIN_52		URN2W_52		URNNO_52		URMED_52			URNNC_52	
19) Blood in urine	BLURN_52		BLU2W_52		BLUNO_52		BUMED_52			BLUNC_52	
20) Kidney stones	STONE_52				KIDNO_52		KDMED_52			KIDNC_52	
21) Vivid nightmares or dreams	DREAM_52		NVD2W_52		NVDNO_52		DRMED_52			NVDNC_52	
22) Insomnia or problems sleeping	INSOM_52		IPS2W_52		IPSNO_52		INMED_52			IPSNC_52	

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

	If NO, go to next question. If YES, indicate severity.				Severity (0= None, 1= Mild, 10= Severe)		Did you experience this symptom due to taking any medication?			
	NO	YES					NO	YES	DON'T KNOW	
1. Pain, aching, or burning in your feet or legs?	FEETP_52 →		Right	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	PAINR_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PLMED_52		
			Left	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	PAINL_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
2. Pins and needles in your feet or legs?	PINSF_52 →		Right	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	PINSR_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	PIMED_52		
			Left	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	PINSL_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
3. Numbness (lack of feeling) in your feet or legs?	NUMBF_52 →		Right	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	NUMBR_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	NBMED_52		
			Left	<input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/>	NUMBL_52	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

If the participant reports bleeding with pain (Q 13.C(2) = YES), inform your clinic coordinator immediately following the interview.

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

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

- No → Yes

GO TO Q 15

ANBLD_52

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

- No → Yes

GO TO Q 13.C.(4)

ANBLP_52

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

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

ANBLPF_52

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

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

IF NO ANAL BLEEDING IN OTHER TIMES (Q 13.C.(4)c = NO), GO TO Q 15.

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

- Daily
 Weekly
 Monthly
 Less than monthly

ANBOTF_52

Q14 contains influenza questions to be administered at V53

16. Continued

<p>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)</p> <p>IF "NO" TO <u>a</u> GO TO NEXT ITEM</p>	<p>a</p> <p>How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?</p>	<p>b</p> <p>When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?</p>	<p>c</p> <p>Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</p>																																												
	NO YES	Name:	NO YES																																												
<p>6) Medication taken by mouth for worms or parasites</p>	<p>WRMDV_52</p>	<p>Name:</p>	<p>WRMD5_52</p>																																												
<p>7) Tranquilizers or sleeping pills</p>	<p>TRNQV_52</p>	<p>Name:</p>	<p>TRNQ5_52</p>																																												
<p>8) Antidepressants or mood elevators</p>	<p>MOODV_52</p>	<p>Name:</p>	<p>MOOD5_52</p>																																												
<p>9) Lithium</p>	<p>LITHV_52</p>	<p>Name:</p>	<p>LITH5_52</p>																																												
<p>10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it:</p> <p>Everyday? <input type="radio"/> No <input type="radio"/> Yes</p> <p>Only when you had active lesions or had an outbreak? <input type="radio"/> No <input type="radio"/> Yes</p>	<p>ACYCV_52 CHACY_52 EPACY_52</p>	<p>Name:</p>	<p>ACYC5_52</p>																																												
<p>11) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction</p>	<p>VIAGR_52</p>	<p>Name:</p>	<p>VIAG5_52</p>																																												
<p>12) Aspirin taken three days or more on a weekly basis</p>	<p>ASPRN_52</p>	<p>Name:</p>	<p>ASPR7_52</p>																																												
<p>13) Medications to lower cholesterol, triglycerides, lipids or blood fat</p> <p>a. <table border="1" style="display: inline-table; vertical-align: middle;"> <tr><td></td><td>0</td><td>1000</td><td>2000</td><td>3000</td><td>4000</td><td>5000</td><td>6000</td><td>7000</td><td>8000</td><td>9000</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> CHDG1_52</p>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>CHOL1_52</p>	<p>Name:</p>	<p>CHL15_52</p>
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16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)		a	b	c																																														
IF "NO" TO a GO TO NEXT ITEM		How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?																																														
		NO YES	Name:	NO YES																																														
14) Medications to treat hypertension	a.	<table border="1"> <tr><td></td><td>0</td><td>1000</td><td>2000</td><td>3000</td><td>4000</td><td>5000</td><td>6000</td><td>7000</td><td>8000</td><td>9000</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	HTDG1_52	HYPT1_52		HYP15_52
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15) Medications to treat diabetes	a.	<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	DIAT1_52	DIAB1_52		DIA15_52											
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16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)		a	b	c
IF "NO" TO a GO TO NEXT ITEM		How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?
		NO YES	Name:	NO YES
16) Medications to treat hepatitis	a.	<input type="radio"/> NO <input type="radio"/> YES HEPT1_52 SKIP TO Q 16.17	HEPD1_52	HEP15_52
	b.	<input type="radio"/> NO <input type="radio"/> YES HEPT2_52 SKIP TO Q 16.17	HEPD2_52	HEP25_52

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG. IF "NO" TO a GO TO Q17.A.			
a	b	c	d
Have you (taken/used) any other medications since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	What did you take this drug for?	Have you taken/used any in the past 5 days?
17) Other	Name:	Used for:	NO YES
a. <input type="radio"/> NO <input type="radio"/> YES ODRG1_52 SKIP TO Q 17.A	DRUG1_52		ODG15_52
b. <input type="radio"/> NO <input type="radio"/> YES ODRG2_52 SKIP TO Q 17.A	DRUG2_52		ODG25_51
c. <input type="radio"/> NO <input type="radio"/> YES ODRG3_52 SKIP TO Q 17.A	DRUG3_52		ODG35_52
d. <input type="radio"/> NO <input type="radio"/> YES ODRG4_52 SKIP TO Q 17.A	DRUG4_52		ODG45_52
e. <input type="radio"/> NO <input type="radio"/> YES ODRG5_52 SKIP TO Q 17.A	DRUG5_52		ODG55_52

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a). IF "NO" TO a GO TO Q17.A.

a Have you (taken/used) any other medications since your last visit [in (MONTH, YEAR)]?	b When specified, what was the name of the (KIND OF DRUG) you took?	c What did you take this drug for?	d Have you taken/used any in the past 5 days?																																																
<p>17) Other</p> <p>f. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG6_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG6_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>10</td></tr> <tr><td></td><td>0</td><td>1</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		0	100		0	10		0	1	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p><input type="radio"/> NO <input type="radio"/> YES</p> <p>ODG65_52</p>																								
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<p>g. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG7_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG7_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>10</td></tr> <tr><td></td><td>0</td><td>1</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		0	100		0	10		0	1	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p>ODG75_52</p>																								
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<p>h. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG8_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG8_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>10</td></tr> <tr><td></td><td>0</td><td>1</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		0	100		0	10		0	1	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p>ODG85_52</p>																								
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<p>i. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG9_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG9_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>10</td></tr> <tr><td></td><td>0</td><td>1</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		0	100		0	10		0	1	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p>ODG95_52</p>																								
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<p>j. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG10_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG10_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>10</td></tr> <tr><td></td><td>0</td><td>1</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		0	100		0	10		0	1	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p>ODG105_52</p>																								
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<p>k. <input type="radio"/> NO <input type="radio"/> YES</p> <p>ODRG11_52</p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG11_52</p> <table border="1"> <tr><td></td><td>0</td><td>100</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> <table border="1"> <tr><td>000</td><td>0000</td><td>0000</td></tr> <tr><td>00</td><td>000</td><td>000</td></tr> <tr><td>70</td><td>80</td><td>90</td></tr> <tr><td>7</td><td>8</td><td>9</td></tr> </table>		0	100		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	000	0000	0000	00	000	000	70	80	90	7	8	9	<p>Used for:</p>	<p>ODG115_52</p>
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I would now like to ask you about your medical coverage.

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

- No **ADAP_52**
- Yes

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

- No → **SKIP TO Q 17.C** **MEDCV_52**
- Yes - did you have

NO YES

- 1) Coverage by an HMO **HMOC_52**
- 2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) **GPIC_52**
- 3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) **IPIC_52**
- 4) Medicaid, Medi-Cal, or Medical Assistance **MCAID_52**
- 5) Medicare (for people over 65 or permanently disabled) **MCARE_52**
- 6) Health care benefits for The Armed Forces or Veteran's Administration, CHAMPUS or CHAMP-VA medical insurance for dependents of military personnel or survivors of disabled veterans. **HCVET_52**

7) Other **OTHER_52**

Specify:

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

- No **INSDG_52**
- Yes

IF NO MEDICAL COVERAGE AND NO PRESCRIPTION COVERAGE (Q 17.B AND Q 17.C = NO), THEN SKIP TO Q 19.

18. Are you currently insured?

- No **INCUR_52**
- Yes

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

- No **DINS_52**
- Yes

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

SERVICE	a		b												
	Have you used (EACH) since your last visit [in (MONTH, YEAR)]?		How many times? (99 = 99 or more)												
1) HMO	NO	YES		0	10	HMONU_52	70	80	90						
	HMOOV_52			0	1		7	8	9						
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care				0	10	DOCNU_52	70	80	90						
	DOCOV_52			0	1		7	8	9						
3) Any other clinic				0	10	CLNUM_52	70	80	90						
	CLOV_52			0	1		7	8	9						
4) Emergency room				0	10	ERNUM_52	70	80	90						
	EROV_52			0	1		7	8	9						
5) Other outpatient service (Specify below)				0	10	OPNUM_52	70	80	90						
	OPOV_52			0	1		7	8	9						

Specify:

21. Since your last visit [in (MONTH, YEAR)], have you seen a

SERVICE	a		b												
	Have you seen one since your last visit [in (MONTH, YEAR)]?		How many times? (99 = 99 or more)												
1) Dental health care provider (such as dentist or dental hygienist)	<input type="radio"/> NO	<input type="radio"/> YES		0	10	DHNUM_52	70	80	90						
	DENTV_52			0	1		7	8	9						

27.

Abbreviated interview

No **ABINT_52**

Yes

28.

Date interview completed

TIME ENDED				
HR		MIN		
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	
<input type="radio"/> 10	<input type="radio"/> 1	<input type="radio"/> 10	<input type="radio"/> 1	AM
<input type="radio"/> 2	<input type="radio"/> 20	<input type="radio"/> 2	<input type="radio"/>	<input type="radio"/>
<input type="radio"/> 3	<input type="radio"/> 30	<input type="radio"/> 3	<input type="radio"/>	
<input type="radio"/> 4	<input type="radio"/> 40	<input type="radio"/> 4	<input type="radio"/>	PM
<input type="radio"/> 5	<input type="radio"/> 50	<input type="radio"/> 5	<input type="radio"/>	<input type="radio"/>
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<input type="radio"/> 7	<input type="radio"/>	<input type="radio"/> 7	<input type="radio"/>	
<input type="radio"/> 8	<input type="radio"/>	<input type="radio"/> 8	<input type="radio"/>	
<input type="radio"/> 9	<input type="radio"/>	<input type="radio"/> 9	<input type="radio"/>	

S4TEH_52
S4TEM_52
S4TEZ_52

29.

Interviewer's signature

INTERVIEWER'S NUMBER									
<input type="radio"/> 0	<input type="radio"/> 100	<input type="radio"/> 200	<input type="radio"/> 300	<input type="radio"/> 400	<input type="radio"/> 500	<input type="radio"/> 600	<input type="radio"/> 700	<input type="radio"/> 800	<input type="radio"/> 900
<input type="radio"/> 0	<input type="radio"/> 10	<input type="radio"/> 20	<input type="radio"/> 30	<input type="radio"/> 40	<input type="radio"/> 50	<input type="radio"/> 60	<input type="radio"/> 70	<input type="radio"/> 80	<input type="radio"/> 90
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INTVN_52

CLINIC IDENTIFIERS
<input type="radio"/> BA Moore clinic
<input type="radio"/> BA Whitman Walker
<input type="radio"/> CH Howard Brown
<input type="radio"/> CH Northwestern
<input type="radio"/> CH CORE
<input type="radio"/> PI
<input type="radio"/> LA Wilshire
<input type="radio"/> LA LAGLC
<input type="radio"/> LA Harbor

CLNID_52

ACASI begins here.

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

INCOM_52

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

- No → **SKIP TO Q 32**
- Yes

FNDIF_52

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

- Less
- Same
- Greater

FNDFL_52

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

- No → **SKIP TO Q 33**
- Yes

JOBHI_52

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"/> |

TSICK_52

STKNE_52

STKNC_52

RETEY_52

JOBPE_52

JOBHE_52

DISAB_52

JOBOT_52

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** **ESMOK_52**
 Yes

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

- No → **SKIP TO Q 34** **SMOKN_52**
 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 **PACKS_52**
 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 set of questions are about alcoholic beverages. They may seem similar, but they are asked in a slightly different way.

Please answer each of the following questions for the past 6 months.

A. How often have you had drinks containing alcohol? **FADRNK_52**

- Never → **STOP - SKIP TO Q 34K**
 Less than monthly Weekly
 Monthly Daily or almost daily

B. During the past 6 months, how many drinks containing alcohol have you had on a typical day when you are drinking? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.) **NADRNK_52**

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

C. During the past 6 months, how often have you had six or more drinks on one occasion? (A "drink" is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.)

- Never Monthly Daily or almost daily
 Less than monthly Weekly **DRNK6_52**

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

- Never Monthly Daily or almost daily
 Less than monthly Weekly **NSDRK_52**

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

- Never Monthly Daily or almost daily
 Less than monthly Weekly **FLDRK_52**

F. How often during the past 6 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?

- Never Monthly Daily or almost daily
 Less than monthly Weekly **MODRNK_52**

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

- Never Monthly Daily or almost daily
 Less than monthly Weekly **GDRNK_52**

H. How often during the past 6 months have you been unable to remember what happened the night before because you had been drinking?

- Never Monthly Daily or almost daily
 Less than monthly Weekly **RDRNK_52**

I. Have you or someone else been injured as a result of your drinking?

- No **HDRNK_52**
 Yes, but not in the past 6 months
 Yes, during the past 6 months

J. Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?

- No **CDRNK_52**
 Yes, but not in the past 6 months
 Yes, during the past 6 months

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

- No Yes **ALTSV_52**

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 last visit [in (MONTH, YEAR)]?

- No → **SKIP TO Q 42** **SEXAV_52**
 Yes

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

- No → **SKIP TO Q 39** **SEXVF_52**
 Yes

GO TO QUESTION 37 ON NEXT PAGE.

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

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

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

NSEXF_52

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

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

NSXAF_52

IF ONLY 1 PARTNER (Q 37.A + Q 37.B = 1), GO TO Q 37.C.1

IF MORE THAN 1 PARTNER (Q 37.A + Q 37.B ≥ 2), GO TO Q 37.C.2

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

- Main partner or someone you have a longstanding relationship with, live with, or partner with. → **GO TO Q 37.D**
- Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with. → **GO TO Q 38.1a** **FPRT1_52**

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

- No → **GO TO Q 38.1b**
- Yes → **GO TO Q 37.D** **FPRTM_52**

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




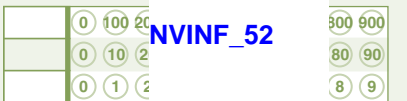



- No
- Yes **MPFIV_52**

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

- Negative
- Positive
- Don't Know **MPHIVF_52**

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 Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).	NO YES OINF1_52	 NOINF_52
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?	COIF1_52	 NCOIF_52
IF MULTIPLE PARTNERS: 3) With how many women did you ejaculate/cum in their mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?	OEJF1_52	 NOEJF_52
4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).	VINF1_52	 NVINF_52
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?	CVIF1_52	 NCVIF_52
IF MULTIPLE PARTNERS: 6) With how many women did you ejaculate/cum in their 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)?	VEJF1_52	 NVEJF_52
7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).	AINF1_52	 NAINF_52

38. Continued

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
<p>IF MULTIPLE PARTNERS: 8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p> <p>IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p>	<p>NO YES CAIF1_52</p>	<p>NCAIF_52</p>
<p>IF MULTIPLE PARTNERS: 9) With how many women did you ejaculate/cum in their anus/butt when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>AEJF1_52</p>	<p>NAEJF_52</p>
<p>10) You used your tongue to touch or lick her anus/butt ("rimming").</p>	<p>RIMF1_52</p>	<p>NRIMF_52</p>
<p>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</p>	<p>LICF1_52</p>	<p>NLICF_52</p>
<p>12) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).</p>	<p>DWKW1_52</p>	<p>NDWKW_52</p>

39. Have you had any sort of sexual activity with a man since your last visit [in (MONTH, YEAR)]?

No → **SKIP TO Q 41.15** **SEXVM_52**
 Yes
 ↓

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

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

	0	100	200	300	400	500	600	700	800	900
	0	10							80	90
	0	1	2	3	4	5	6	7	8	9

NSEXM_52

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

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

NNSXM_52

IF ONLY 1 PARTNER (Q 40.A + Q 40.B = 1), GO TO Q 40.C.1

IF MORE THAN 1 PARTNER (Q 40.A + Q 40.B ≥ 2), GO TO Q 40.C.2

SERIAL #

40. Continued

C.1) You said you had intercourse or sexual activity with only one man since your last visit [in (MONTH, YEAR)]. How would you describe this man? **MPRT1_52**

Main partner or someone you have a longstanding relationship with, live with, or partner with. → **GO TO Q 40.D**

Casual partner, one time partner, or someone with whom you have not developed a longstanding, close relationship with. → **GO TO Q 41.1a**

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

No → **GO TO Q 41.1b** Yes → **GO TO Q 40.D** **MPRTM_52**

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

No Yes **MPMIV_52**

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

Negative Positive Don't Know **MPHIVM_52**

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

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a man since your last visit [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																														
1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (4).	NO YES ORIN1_52	<table border="1" style="font-size: small;"> <tr><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>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>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> NOINM_52	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																							
IF MULTIPLE PARTNERS: 2) Thinking of the times you put your penis in their mouth, with how many of those men did you use a condom every time, even if it broke, tore, or slipped? IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom every time, even if it broke, tore, or slipped?	COIN1_52	<table border="1" style="font-size: small;"> <tr><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>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>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> NCOIM_52	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																							
IF MULTIPLE PARTNERS: 3) With how many men did you ejaculate/cum in their mouth when you did not use a condom (or when a condom failed)? IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?	OEJM1_52	<table border="1" style="font-size: small;"> <tr><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>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>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> NOEJM_52	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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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 [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
<p>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</p>	<p>NO YES ANIN1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NAINM_52</p>
<p>IF MULTIPLE PARTNERS: 5b.) Thinking of the times you put your penis in their anus/butt, with how many of those men did you use a condom every time, even if it broke, tore, or slipped?</p> <p>If any unprotected anal sex (Q5b < Q4) then read: For those men with whom you did not use a condom, 5b.1) Were any of these men HIV positive? 5b.2) Were any of these men HIV negative? If 5b.1 or 5b.2 = Don't Know/Not Sure, skip to 6b. 5b.3) Were you unsure of the HIV status of any of these men?</p> <p>IF ONE PARTNER: 5a.) Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped?</p> <p>If 5a = No, 5a.1) What was the HIV status of your partner when you did not use a condom?</p>	<p>NO YES CAIN1_52</p> <p>DON'T KNOW/NOT SURE NEG. POS. HIVSTAT1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NCAIM_52</p> <p>DON'T KNOW/NOT SURE NO YES 5b.1) HPAIM_52 5b.2) HNAIM_52 5b.3) HUAIM_52</p>
<p>IF MULTIPLE PARTNERS: 6b.) With how many men did you ejaculate/cum in their anus/butt when you did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER: 6a.) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES AEJM1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NAEJM_52</p>
<p>7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES ORRC1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NORCM_52</p>
<p>IF MULTIPLE PARTNERS: 8) Thinking of the times when a man put his penis in your mouth, with how many of those men was a condom used every 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 every time, even if it broke, tore, or slipped?</p>	<p>CORR1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NCORM_52</p>
<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>OREM1_52</p>	<p>0 100 200 300 400 500 600 700 800 900 NOREM_52</p>

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 [in (MONTH, YEAR)]?	b How many men did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)																																				
10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).	NO YES ANRC1_52	<table border="1"> <tr><td></td><td>0</td><td>100</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8</td><td>9</td></tr> </table> <p>NARIM_52</p>		0	100								800	900		0	10								80	90		0	1								8	9
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<p>IF MULTIPLE PARTNERS:</p> <p>11b.) Thinking of the times when a man put his penis in your anus/butt, with how many of those men was a condom used every time, even if it broke, tore, or slipped?</p> <p>If any unprotected anal sex (Q11b < Q10) then read: Of the men who did not use a condom, 11b.1) Were any of these men HIV positive? 11b.2) Were any of these men HIV negative? If 11b.1 or 11b.2 = Don't Know/Not Sure, skip to 12b. 11b.3) Were you unsure of the HIV status of any of these men?</p> <p>IF ONE PARTNER:</p> <p>11a.) Thinking of the times when he put his penis in your anus/butt, was a condom used every time, even if it broke, tore, or slipped?</p> <p>If 11a = No, 11a.1) What was the HIV status of your partner when he did not use a condom?</p>	<p>CANR1_52</p> <p>NEG. POS. DON'T KNOW/NOT SURE HIVSTAT2_52</p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td></td><td></td><td></td><td></td><td></td><td></td><td></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></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><td></td></tr> </table> <p>NCARM_52</p> <p>DON'T KNOW/NOT SURE NO YES 11b.1) HPARM_52 11b.2) HNARM_52 11b.3) HUARM_52</p>		0	100								800	900		0	10	20	30	40	50	60	70		80	90		0	1	2	3	4	5	6	7	8	9	
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<p>IF MULTIPLE PARTNERS:</p> <p>12b.) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)?</p> <p>IF ONE PARTNER:</p> <p>12a.) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</p>	<p>NO YES AREM1_52</p>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td></td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8</td><td>9</td></tr> </table> <p>NAREM_52</p>		0	100	200	300	400	500	600	700		800	900		0	10								80	90		0	1								8	9
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13) You used your tongue to touch or lick his anus/butt ("rimming").	RIMI1_52	<table border="1"> <tr><td></td><td>0</td><td>100</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>8</td><td>9</td></tr> </table> <p>NRMIM_52</p>		0	100								800	900		0	10								80	90		0	1								8	9
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14) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).	DWKS1_52	<table border="1"> <tr><td></td><td>0</td><td>100</td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td></td><td></td><td></td><td></td><td></td><td></td><td></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><td></td></tr> </table> <p>NDWKM_52</p>		0	100								800	900		0	10								80	90		0	1	2	3	4	5	6	7	8	9	
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41.15) Have you met any new partners to engage in any type of sexual activity since your last visit [in (MONTH, YEAR)]?

- No → SKIP TO Q 42 METNW_52
 Yes

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

- | | | | | | |
|---|--------|-----------|---|--------|----------|
| a) on the internet | NO YES | METIN_52 | f) in a park or other outdoor public place | NO YES | METOP_52 |
| b) at a party (including a circuit party) | | METPY_52 | g) in a bathroom, bookstore, or other indoor public place | | METIP_52 |
| c) through an advertisement in a newspaper or other new | | METAD_52 | h) at a place where drugs were used or exchanged | | METDR_52 |
| d) at a bar | | METBAR_52 | i) other place not listed above | | METOT_52 |
| e) at a bath house | | METBH_52 | | | |

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 last visit [in (MONTH, YEAR)]?

	a How about (EACH) Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?		b How often did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]?				c How did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]? [Mark all that apply.]					
	NO	YES	DAILY	WEEKLY	MONTHLY	LESS OFTEN	SNORTED	SWALLOWED	PUT IN ANUS ("booty bumped")	SMOKED	INJECTED (Intravenous use)	
Pot, Marijuana or Hash	HASHV_52		<input type="radio"/>	HASHF_52		<input type="radio"/>						
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	POPPV_52		<input type="radio"/>	POPPF_52		<input type="radio"/>						
Crack or cocaine that you smoke	CRACV_52		<input type="radio"/>	CRACF_52		<input type="radio"/>						
Other forms of cocaine	OCOKV_52		<input type="radio"/>	OCOKF_52		<input type="radio"/>	COCSNR_52	COCSWL_52	COCANU_52		COCINJ_52	
Speed, Meth or Ice	UPPRV_52		<input type="radio"/>	UPPRF_52		<input type="radio"/>	SMISNR_52	SMISWL_52	SMIANU_52	SMISMK_52		SMIINJ_52
Heroin	HEROV_52		<input type="radio"/>	HEROF_52		<input type="radio"/>	HERSNR_52	HERSWL_52	HERANU_52	HERSMK_52		HERINJ_52
Speedball (heroin and cocaine together)	SPEBV_52		<input type="radio"/>	SPEBF_52		<input type="radio"/>	SPBSNR_52	SPBSWL_52	SPBANU_52	SPBSMK_52		SPBINJ_52
Ecstasy, XTC, X or MDMA	MDAV_52		<input type="radio"/>	MDAF_52		<input type="radio"/>						
Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction (Show list of performance enhancing drugs to prompt and assist with recall.)	SEXPV_52		<input type="radio"/>	SEXPF_52		<input type="radio"/>						
Other kinds of street/club drugs	STMDV_52		GO TO Q 43.A									
Specify:	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST1DF_52		<input type="radio"/>						
	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST2DF_52		<input type="radio"/>						
	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST3DF_52		<input type="radio"/>						
	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST4DF_52		<input type="radio"/>						
	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST5DF_52		<input type="radio"/>						
	<input type="text"/>	<input type="text"/>	<input type="radio"/>	ST6DF_52		<input type="radio"/>						

IF NO INJECTING DRUG USE (Q 42.c injected=NO), SKIP TO Q 49

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

- No **RCDSG_52**
- Yes

B. Do you currently inject drugs?

- No **RCDNO_52**
- Yes

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

Speedball (cocaine and heroin together)

	0	10	TINSB_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

Cocaine by itself

	0	10	TINCO_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

Heroin by itself

	0	10	TINHO_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

Speed by itself

	0	10	TINSO_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

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

- No → **SKIP TO Q 46** **SHRNW_52**
- Yes

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

	0	10	TSHNW_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

B. With how many different people?

	0	10	SHWNP_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

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

- No → **SKIP TO Q 47** **SH2OR_52**
- Yes

B. How many times?

	0	10	TSH2O_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

C. With how many different people?

	0	10	DPH2O_52				70	80	90	
	0	1	2	3	4	5	6	7	8	9

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

- Never **FBLEA_52**
- Less than half the time
- About half the time
- Most of the time
- Always

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

- No → **SKIP TO Q 49** **PNEP_52**
- Yes

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

- Less than half the time **HONEP_52**
- Half the time
- Most of the time
- Always

C. Do you have another source of clean needles?

- No **OSCLN_52**
- Yes

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

- No **DRGTP_52**
- Yes

Interviewer Instructions:

Thank the participant.

Record the time ended on page 22.

