

Effective January 18, 2011, the variable visit number suffix was changed from 2 digits (i.e., VARIABLE_54) to a 3 digit suffix (i.e., VARIABLE_054) and affects ALL visit questionnaire variables from the first visit onward.

- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make **NO** stray marks.
- **DO NOT** fold this form.
- * Indicates priority questions for abbreviated interview

CORRECT MARK



INCORRECT MARKS



ID NUMBER			
MACSID			
0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

VISIT NO.
5 3 0
0
2 2
3
4 4
5 5
6 6
7 7
8 8
9 9

TIME BEGAN	
HR	MIN
3	30
4	40
5	50
6	6
7	7
8	8
9	9

DATE		
MONTH	DAY	YEAR
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar		
<input type="radio"/> Apr		
<input type="radio"/> May		
<input type="radio"/> June	3	3
<input type="radio"/> July	4	
<input type="radio"/> Aug	5	
<input type="radio"/> Sept	6	
<input type="radio"/> Oct	7	
<input type="radio"/> Nov	8	
<input type="radio"/> Dec	9	

S4TBH_53

S4TBM_53 AM

S4TBZ_53

DAT4M_53

DAT4D_53

DAT4Y_53

VISIT_53

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

- No
- Yes

IF "NO," GO TO Q 2

CANCD_53

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

1) Site: _____

Type: _____

0 1M 2M 3M 4M 5M 6M 7M 8M 9M

0 100 20 CAN1T_53 00 600 900

0 10 20 30 40 50 60 70 80 90

0 1 2 3 4 5 6 7 8 9

2) Site: _____

Type: _____

0 1M 2M 3M 4M 5M 6M 7M 8M 9M

0 100 20 CAN2T_53 700 600 900

0 10 20 30 40 50 60 70 80 90

0 1 2 3 4 5 6 7 8 9

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

J F M CAN1M_53 S O N D

00 01 02 CAN1Y_53 08 09 10 11

J F M CAN2M_53 S O N D

00 01 02 CAN2Y_53 08 09 10 11

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

Name of hospital/clinic or doctor

Address

City State

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

Name of hospital/clinic or doctor

Address

City State

GET MEDICAL RELEASE



* 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 → IF "NO," GO TO Q 3 **AID_53**
 Yes
 ↓

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)]?																																																																																																
1) Type <input style="width: 150px; height: 20px;" type="text"/> <table style="display: inline-table; vertical-align: top; margin-left: 10px;"> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">1M</td><td style="border: 1px solid black; width: 20px; text-align: center;">2M</td><td style="border: 1px solid black; width: 20px; text-align: center;">3M</td><td style="border: 1px solid black; width: 20px; text-align: center;">4M</td><td style="border: 1px solid black; width: 20px; text-align: center;">5M</td><td style="border: 1px solid black; width: 20px; text-align: center;">6M</td><td style="border: 1px solid black; width: 20px; text-align: center;">7M</td><td style="border: 1px solid black; width: 20px; text-align: center;">8M</td><td style="border: 1px solid black; width: 20px; text-align: center;">9M</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">100</td><td style="border: 1px solid black; width: 20px; text-align: center;">200</td><td style="border: 1px solid black; width: 20px; text-align: center;">300</td><td style="border: 1px solid black; width: 20px; text-align: center;">400</td><td style="border: 1px solid black; width: 20px; text-align: center;">500</td><td style="border: 1px solid black; width: 20px; text-align: center;">600</td><td style="border: 1px solid black; width: 20px; text-align: center;">700</td><td style="border: 1px solid black; width: 20px; text-align: center;">800</td><td style="border: 1px solid black; width: 20px; text-align: center;">900</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">10</td><td style="border: 1px solid black; width: 20px; text-align: center;">20</td><td style="border: 1px solid black; width: 20px; text-align: center;">30</td><td style="border: 1px solid black; width: 20px; text-align: center;">40</td><td style="border: 1px solid black; width: 20px; text-align: center;">50</td><td style="border: 1px solid black; width: 20px; text-align: center;">60</td><td style="border: 1px solid black; width: 20px; text-align: center;">70</td><td style="border: 1px solid black; width: 20px; text-align: center;">80</td><td style="border: 1px solid black; width: 20px; text-align: center;">90</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">1</td><td style="border: 1px solid black; width: 20px; text-align: center;">2</td><td style="border: 1px solid black; width: 20px; text-align: center;">3</td><td style="border: 1px solid black; width: 20px; text-align: center;">4</td><td style="border: 1px solid black; width: 20px; text-align: center;">5</td><td style="border: 1px solid black; width: 20px; text-align: center;">6</td><td style="border: 1px solid black; width: 20px; text-align: center;">7</td><td style="border: 1px solid black; width: 20px; text-align: center;">8</td><td style="border: 1px solid black; width: 20px; text-align: center;">9</td></tr> </table> 2) Type <input style="width: 150px; height: 20px;" type="text"/> <table style="display: inline-table; vertical-align: top; margin-left: 10px;"> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">1M</td><td style="border: 1px solid black; width: 20px; text-align: center;">2M</td><td style="border: 1px solid black; width: 20px; text-align: center;">3M</td><td style="border: 1px solid black; width: 20px; text-align: center;">4M</td><td style="border: 1px solid black; width: 20px; text-align: center;">5M</td><td style="border: 1px solid black; width: 20px; text-align: center;">6M</td><td style="border: 1px solid black; width: 20px; text-align: center;">7M</td><td style="border: 1px solid black; width: 20px; text-align: center;">8M</td><td style="border: 1px solid black; width: 20px; text-align: center;">9M</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">100</td><td style="border: 1px solid black; width: 20px; text-align: center;">200</td><td style="border: 1px solid black; width: 20px; text-align: center;">300</td><td style="border: 1px solid black; width: 20px; text-align: center;">400</td><td style="border: 1px solid black; width: 20px; text-align: center;">500</td><td style="border: 1px solid black; width: 20px; text-align: center;">600</td><td style="border: 1px solid black; width: 20px; text-align: center;">700</td><td style="border: 1px solid black; width: 20px; text-align: center;">800</td><td style="border: 1px solid black; width: 20px; text-align: center;">900</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">10</td><td style="border: 1px solid black; width: 20px; text-align: center;">20</td><td style="border: 1px solid black; width: 20px; text-align: center;">30</td><td style="border: 1px solid black; width: 20px; text-align: center;">40</td><td style="border: 1px solid black; width: 20px; text-align: center;">50</td><td style="border: 1px solid black; width: 20px; text-align: center;">60</td><td style="border: 1px solid black; width: 20px; text-align: center;">70</td><td style="border: 1px solid black; width: 20px; text-align: center;">80</td><td style="border: 1px solid black; width: 20px; text-align: center;">90</td></tr> <tr><td style="border: 1px solid black; width: 20px; text-align: center;">0</td><td style="border: 1px solid black; width: 20px; text-align: center;">1</td><td style="border: 1px solid black; width: 20px; text-align: center;">2</td><td style="border: 1px solid black; width: 20px; text-align: center;">3</td><td style="border: 1px solid black; width: 20px; text-align: center;">4</td><td style="border: 1px solid black; width: 20px; text-align: center;">5</td><td style="border: 1px solid black; width: 20px; text-align: center;">6</td><td style="border: 1px solid black; width: 20px; text-align: center;">7</td><td style="border: 1px solid black; width: 20px; text-align: center;">8</td><td style="border: 1px solid black; width: 20px; text-align: center;">9</td></tr> </table>	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	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	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">J</td> <td style="border: 1px solid black; width: 20px; text-align: center;">F</td> <td style="border: 1px solid black; width: 20px; text-align: center;">M</td> <td style="border: 1px solid black; width: 20px; text-align: center;">AIDM1_53</td> <td style="border: 1px solid black; width: 20px; text-align: center;">S</td> <td style="border: 1px solid black; width: 20px; text-align: center;">O</td> <td style="border: 1px solid black; width: 20px; text-align: center;">N</td> <td style="border: 1px solid black; width: 20px; text-align: center;">D</td> </tr> <tr> <td style="border: 1px solid black; width: 20px; text-align: center;">00</td> <td style="border: 1px solid black; width: 20px; text-align: center;">01</td> <td style="border: 1px solid black; width: 20px; text-align: center;">02</td> <td style="border: 1px solid black; width: 20px; text-align: center;">AIDY1_53</td> <td style="border: 1px solid black; width: 20px; text-align: center;">08</td> <td style="border: 1px solid black; width: 20px; text-align: center;">09</td> <td style="border: 1px solid black; width: 20px; text-align: center;">10</td> <td style="border: 1px solid black; width: 20px; text-align: center;">11</td> </tr> </table>	J	F	M	AIDM1_53	S	O	N	D	00	01	02	AIDY1_53	08	09	10	11
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																																																																																								
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																																																																																								
J	F	M	AIDM1_53	S	O	N	D																																																																																										
00	01	02	AIDY1_53	08	09	10	11																																																																																										

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

Name of hospital/clinic or doctor

Address

City

State

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

Name of hospital/clinic or doctor

Address

City

State

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

No → IF "NO," GO TO Q 4 **PNEUM_53**
 Yes
 ↓

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

J	F	M	MPNEU_53	O	N	D
00	01	02	PNEUY_53	09	10	11

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

Name of hospital/clinic or doctor

Address

City

State

Clinician's Notes: Method of Diagnosis

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_53

SKIP
TO Q 5

B. IF YES: When was your last test?

Month: J F M PPDM_53 S O N D
Day: 00 01 02 PPDY_53 08 09 10 11

C. Was it positive?

NO YES
PSPPD_53

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

TBDXE_53

SKIP
TO Q 6

B. Was the TB in your lungs?

TBILG_53

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

TBOLG_53

GET
M
E
D
I
C
A
L

R
E
L
E
A
S
E

* 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_53

Yes → How many separate times were you a patient in a hospital since your last visit [in (MONTH, YEAR)]?

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. 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 M A M J J A S O N D
DAY: 0 10 HOS1M_53
0 1 HOS1D_53 8 9
YEAR: 00 01 02 03 04 05 06 07 08 09 10 11 HOS1Y_53

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

0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9 HOS1N_53 NIGHTS

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

What was the name and address of the physician who diagnosed the condition(s)?
IF AIDS RELATED,
CODE IN QUESTIONS 1-3 AS APPROPRIATE

Name of hospital/clinic or doctor

Address

City

State

1) Diagnosis or procedure

V E P TYHO11_53

H1DX1_53

2) Diagnosis or procedure

V E P TYHO12_53

H1DX2_53

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

SERIAL #

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

MO		J	F	S	O	N	D
DAY		0	1	2	3	4	5
YEAR		00	01	02	03	04	05

HOS2M_53
HOS2D_53
HOS2Y_53

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

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

NIGHTS HOS2N_53

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_53</p> <p>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</p> <p>0 100 200 300 400 500 600 700 800 900</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_53</p> <p>0 1M 2M 3M 4M 5M 6M 7M 8M 9M</p> <p>0 100 200 300 400 500 600 700 800 900</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_53

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_53

Yes

Don't know

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

	J	F	M	S	O	N	D
	00	01	02	03	04	05	06

DEPRM_53
DEPRY_53

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_53

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.

Not applicable for those participants who do not have living blood-related family members or do not know them because they are adopted. SKIP TO Q 9 NOBRF_53

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_53	<input type="radio"/>
b. angina, which often causes chest pain?	<input type="radio"/>	<input type="radio"/> CPHDR_53	<input type="radio"/>
c. a heart attack or myocardial infarction (MI) before age 55?	<input type="radio"/>	<input type="radio"/> HRATR_53	<input type="radio"/>
d. congestive heart failure or CHF?	<input type="radio"/>	<input type="radio"/> CHFR_53	<input type="radio"/>
e. a stroke or CVA?	<input type="radio"/>	<input type="radio"/> STROR_53	<input type="radio"/>
f. mini-strokes or transient ischemic attacks (TIA)?	<input type="radio"/>	<input type="radio"/> TIAR_53	<input type="radio"/>
g. high cholesterol, high triglycerides, high lipids or too much fat in their blood?	<input type="radio"/>	<input type="radio"/> HYPER_53	<input type="radio"/>
h. high blood sugar or diabetes?	<input type="radio"/>	<input type="radio"/> DIABR_53	<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 **CANCER_53**

IF YES: Was it:

	NO	YES	DON'T KNOW
a. Skin cancer	<input type="radio"/>	<input type="radio"/> SCANR_53	<input type="radio"/>
b. Colon cancer	<input type="radio"/>	<input type="radio"/> CCANR_53	<input type="radio"/>
c. Prostate cancer	<input type="radio"/>	<input type="radio"/> PCANR_53	<input type="radio"/>
d. Cervical cancer (female family members)	<input type="radio"/>	<input type="radio"/> VCANR_53	<input type="radio"/>
e. Anal cancer	<input type="radio"/>	<input type="radio"/> ACANR_53	<input type="radio"/>
f. Other cancer	<input type="radio"/>	<input type="radio"/> OCANR_53	<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 **APAPS_53**
 Yes
 Don't Know

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

	J	F	M	A	M	J	J	A	S	O	N	D	PAPSM_53
	00	01	02	03	04	05	06	07	08	09	10	11	PAPSY_53

(3) Were the results abnormal?

No **ABRAP_53**
 Yes
 Unable to evaluate/don't know

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

Name of doctor	
Name of hospital/center/clinic	
City	State

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_53

* 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_53

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

	1	2	3	4	5	6	7	8	9
--	---	---	---	---	---	---	---	---	---

TIMES **NBIOP_53**

(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> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">10</td> <td style="width: 20px; height: 20px; text-align: center;">20</td> <td style="width: 20px; height: 20px; text-align: center;">30</td> <td style="width: 20px; height: 20px; text-align: center;">40</td> <td style="width: 20px; height: 20px; text-align: center;">50</td> <td style="width: 20px; height: 20px; text-align: center;">60</td> <td style="width: 20px; height: 20px; text-align: center;">70</td> <td style="width: 20px; height: 20px; text-align: center;">80</td> <td style="width: 20px; height: 20px; text-align: center;">90</td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIOP1_53</p>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>Specify:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIDX1_53</p>		0	1	2	3	4	5	6	7	8	9	<p>Name of doctor _____</p> <p>Name of hospital/center/clinic _____</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
	0	1	2	3	4	5	6	7	8	9																									
<p>2) Specify:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">10</td> <td style="width: 20px; height: 20px; text-align: center;">20</td> <td style="width: 20px; height: 20px; text-align: center;">30</td> <td style="width: 20px; height: 20px; text-align: center;">40</td> <td style="width: 20px; height: 20px; text-align: center;">50</td> <td style="width: 20px; height: 20px; text-align: center;">60</td> <td style="width: 20px; height: 20px; text-align: center;">70</td> <td style="width: 20px; height: 20px; text-align: center;">80</td> <td style="width: 20px; height: 20px; text-align: center;">90</td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIOP2_53</p>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>Specify:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIDX2_53</p>		0	1	2	3	4	5	6	7	8	9	<p>Name of doctor _____</p> <p>Name of hospital/center/clinic _____</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
	0	1	2	3	4	5	6	7	8	9																									
<p>3) Specify:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">10</td> <td style="width: 20px; height: 20px; text-align: center;">20</td> <td style="width: 20px; height: 20px; text-align: center;">30</td> <td style="width: 20px; height: 20px; text-align: center;">40</td> <td style="width: 20px; height: 20px; text-align: center;">50</td> <td style="width: 20px; height: 20px; text-align: center;">60</td> <td style="width: 20px; height: 20px; text-align: center;">70</td> <td style="width: 20px; height: 20px; text-align: center;">80</td> <td style="width: 20px; height: 20px; text-align: center;">90</td> </tr> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIOP3_53</p>		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>Specify:</p> <div style="border: 1px solid black; height: 40px; margin-bottom: 5px;"></div> <table border="1" style="border-collapse: collapse; width: 100%;"> <tr> <td style="width: 20px; height: 20px;"></td> <td style="width: 20px; height: 20px; text-align: center;">0</td> <td style="width: 20px; height: 20px; text-align: center;">1</td> <td style="width: 20px; height: 20px; text-align: center;">2</td> <td style="width: 20px; height: 20px; text-align: center;">3</td> <td style="width: 20px; height: 20px; text-align: center;">4</td> <td style="width: 20px; height: 20px; text-align: center;">5</td> <td style="width: 20px; height: 20px; text-align: center;">6</td> <td style="width: 20px; height: 20px; text-align: center;">7</td> <td style="width: 20px; height: 20px; text-align: center;">8</td> <td style="width: 20px; height: 20px; text-align: center;">9</td> </tr> </table> <p style="text-align: center;">BIDX3_53</p>		0	1	2	3	4	5	6	7	8	9	<p>Name of doctor _____</p> <p>Name of hospital/center/clinic _____</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>
	0	10	20	30	40	50	60	70	80	90																									
	0	1	2	3	4	5	6	7	8	9																									
	0	1	2	3	4	5	6	7	8	9																									

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_53**
- B. Thrush (yeast in your mouth) **THRSH_53**
- C. Sinusitis, a sinus infection that requires antibiotics **SINUS_53**
- D. Bronchitis **BRONC_53**
- E. Pancreatitis **PANCS_53**
- F. Prostate problems (not cancer) **PROST_53**
- G. Erectile dysfunction (erectile problems) **ERDYS_53**
- H. High blood pressure or hypertension **HBPHT_53**
- I. Anemia, low RBC, low hemoglobin **ANEMA_53**
- J. High cholesterol, high triglycerides, high lipids or too much fat in your blood **HCHOL_53**
- K. High blood sugar or diabetes **HBSUG_53**
- L. Arthritis **ARTHR_53**
 IF YES: Was it: Rheumatoid
 (Read and answer each.) Osteoarthritis or degenerative
Other

Specify: _____

Don't know **DKWAR_53**

- *M. Angina or chest pain caused by your heart **ANGIN_53**
- *N. Heart attack or myocardial infarction (MI) **HRTAT_53**
- *O. Congestive heart failure or CHF **HRTFA_53**
- *P. Stroke or Cerebrovascular accident (CVA) **STROK_53**
- *Q. Mini-strokes or transient ischemic attacks (TIA) **TIA_53**
- *R. Too fast, too slow, or irregular heart beat **IRHB_53**
- *S. Any blood vessels (arteries) that were blocked or closed **IF NO, SKIP TO Q U** **BVES_53**
- *T. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas **OBVES_53**
- *U. A blood clot in your legs **BCLG_53**
- *V. A blood clot in your lungs **BCLN_53**
- *W. Seizure or convulsions **SEZUR_53**
- *X. Osteoporosis (bone thinning) **OSTEO_53**
- *Y. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis **HIPNE_53**
- *Z. Kidney disease/Renal failure **KIDND_53**
- AA. An elevated liver enzyme **LIVDE_53**

10BB.1 Were you diagnosed with any broken or fractured bone(s) on or after the age of 30?
 No Yes Not applicable (younger than 30)
 IF "NO," GO TO 10CC **BBONE_53**

If yes... Tell me about each separate incident in which you had broken or fractured one or more bones, starting with the most recent:

Incident 1
10BB.1a What was fractured?

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

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

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

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

10BB.1b How old were you when this happened?

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

10BB.1c Did that fracture occur... (Select one option)

- 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 **FROCR1_53**

Incident 2
10BB.2a What was fractured?

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

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

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

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

10BB.2b How old were you when this happened?

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

10BB.2c Did that fracture occur... (Select one option)

- 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 **FROCR2_53**
- Don't know

SERIAL #

Incident 3

10BB.3a What was fractured?

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT31_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT32_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

10BB.3b How old were you when this happened?

	0	10	BBAGE3_53						80	90
	0	1	2	3	4	5	6	7	8	9

10BB.3c Did that fracture occur... (Select one option)

- 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 **FROCR3_53**
- Don't know

Incident 4

10BB.4a What was fractured?

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT41_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT42_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

10BB.4b How old were you when this happened?

	0	10	BBAGE4_53						70	80	90
	0	1	2	3	4	5	6	7	8	9	

10BB.4c Did that fracture occur... (Select one option)

- 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 **FROCR4_53**
- Don't know

Incident 5

10BB.5a What was fractured?

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT51_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

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

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	100	FRSIT52_53							800	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

10BB.5b How old were you when this happened?

	0	10	BBAGE5_53						70	80	90
	0	1	2	3	4	5	6	7	8	9	

10BB.5c Did that fracture occur... (Select one option)

- 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 **FROCR5_53**
- Don't know
- More than 5 diagnosed fracture incidents **MOR5F_53**

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
VIDE_53
EYDIA_53

SKIP TO b

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	EYCON_53				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 and Sinuses

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

NO YES
VIDEN_53
ENDIA_53

SKIP TO c

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	ENCON_53				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 and Blood Vessels

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

NO YES
VIDHT_53

GET MEDICAL RELEASE

SKIP TO d

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	HTCON_53				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 and Bronchial Tubes

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

NO YES
VIDLG_53
LGDIA_53

SKIP TO e

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	LGCON_53				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, Intestines, or Liver Disease

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

NO YES
VIDSL_53
SLDIA_53

SKIP TO f

IF LIVER DISEASE,
GET MEDICAL RELEASE

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	SLCON_53				600	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_53
JMDIA_53

SKIP TO g

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	JMCON_53				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, Urinary and Rectal

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

NO YES
VIDGU_53
GUDIA_53

SKIP TO h

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	GUCON_53				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
VIDSK_53
SKDIA_53

SKIP TO i

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	SKCON_53				600	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

See Appendix 9 in guidelines for list of neurology diagnosis codes.

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

NO YES
VIDNS_53

GET MEDICAL RELEASE

SKIP TO j

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	NSCON_53				700	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_53
PYDIA_53

SKIP TO k

Specify:

0	1M	2M	3M	4M	5M	6M	7M	8M	9M
0	100	PYCON_53				700	800	900	
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9

SERIAL #

CC. Continued

k) Hormones or Endocrine system

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDHO_53
HODIA_53

SKIP TO I

Specify:

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

l) Blood

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDBF_53

GET MEDICAL RELEASE

SKIP TO m

Specify:

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

m) Allergy and Immune system other than HIV infection

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDAL_53
AIDIA_53

SKIP TO n

Specify:

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

n) Other

IF YES: Was there a diagnosis?

What was the diagnosis?

NO YES
VIDO_53
ODIA_53

SKIP TO Q11.A

1.

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

2.

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

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_53**
- 2) Sores in genital region **HERPG_53**
- 3) Sores in the anal or rectal areas **HERPA_53**
- 4) Sores elsewhere on your body **HERPE_53**

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_53

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_53

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_53

IF "NO," SKIP TO (B)

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

SYPHN_53

- New infection
- Continued or relapse

B) Any form of gonorrhea

GONOR_53

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

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

UGONA_53

D) Oral gonorrhea (of the mouth or throat)

OGONA_53

E) Rectal gonorrhea (of the rectum)

RGONA_53

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

URETC_53

G.1) Genital warts (condylomata acuminata)

WARTG_53

IF "NO," SKIP TO (H)

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

WRTGN_53

- New infection
- Continued or relapse

H.1) Anal warts (condylomata acuminata)

WARTS_53

IF "NO," SKIP TO (I)

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

WRTSN_53

- New infection
- Continued or relapse

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

PARAA_53

Specify:

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	DIZZI_53		DIZ2W_53		DIZNO_53		DZMED_53			DIZNC_53	
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	FATIG_53		FAT2W_53		FATIN_53		FTMED_53			FATNC_53	
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	FEVER_53		FEV2W_53		FEVRN_53		FVMED_53			FEVNC_53	
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	HEADA_53		HED2W_53		HEADN_53		HDMED_53			HEANC_53	
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	RASH_53		RAS2W_53		RASHN_53		RHMED_53			RSHNC_53	
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	GLAND_53		GLN2W_53		GLANN_53		GLMED_53			GLANC_53	
7) Diarrhea for at least 3 consecutive days	DIARR_53		DIA2W_53		DIARN_53		DIMED_53			DIANC_53	
8) Drenching sweats at night on at least 3 occasions	SWEAT_53		SWT2W_53		SWETN_53		SWMED_53			SWENC_53	
9) Nausea, vomiting	VOMIT_53		VOT2W_53		VOTNO_53		VTMED_53			VOTNC_53	
10) Abdominal pain, bloating, cramps	BLOAT_53		ABP2W_53		ABPNO_53		ABMED_53			ABPNC_53	
11) Ascites (fluid buildup in the stomach or abdomen)	ASCIT_53		ASC2W_53		ASCNO_53		ASMED_53			ASCNC_53	
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	JDICE_53		JDI2W_53		JDINO_53		JDMED_53			JDINC_53	
13) An unusual bump or skin discoloration that lasted at least two weeks	BRUIS_53				BRUSN_53		BRMED_53			BRUNC_53	
14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	WTLOS_53				WTLSN_53		WTMED_53			WTLNC_53	

SERIAL #

13.A. Continued

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
15) Unusual bleeding or bleeding that is difficult to stop	BLEED_53				BLDNO_53		BLMED_53			BLDNC_53	
16) Muscle pain or weakness	MPAIN_53		MPW2W_53		MPWNO_53		MPMED_53			MPWNC_53	
17) Joint pain	JOINT_53		JNT2W_53		JNTNO_53		JTMED_53			JNTNC_53	
18) Painful urination	PURIN_53		URN2W_53		URNNO_53		URMED_53			URNNC_53	
19) Blood in urine	BLURN_53		BLU2W_53		BLUNO_53		BUMED_53			BLUNC_53	
20) Kidney stones	STONE_53				KIDNO_53		KDMED_53			KIDNC_53	
21) Vivid nightmares or dreams	DREAM_53		NVD2W_53		NVDNO_53		DRMED_53			NVDNC_53	
22) Insomnia or problems sleeping	INSOM_53		IPS2W_53		IPSNO_53		INMED_53			IPSNC_53	
23) Persistent dry mouth	DRYMO_53		DRY2W_53		DRYNO_53		DMMED_53			DRYNC_53	

13.B. Since your last visit [in (MONTH, YEAR)], 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

FEETP_53 →

PINSF_53 →

NUMBF_53 →

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

Right Left

0 1 2 PAINR_53 8 9 10

0 1 2 PAINL_53 8 9 10

Right Left

0 1 2 PINSR_53 8 9 10

0 1 2 PINSL_53 8 9 10

Right Left

0 1 2 NUMBR_53 8 9 10

0 1 2 NUMBL_53 8 9 10

Did you experience this symptom due to taking any medication?

NO YES DON'T KNOW

PLMED_53

PIMED_53

NBMED_53

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 → GO TO Q 14 ANBLD_53

Yes

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

- No → **GO TO Q 13.C.(4)**
 Yes **ANBLP_53**

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

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_53**

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

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

ANBSX_53
ANBBM_53
ANBOT_53

IF NO ANAL BLEEDING IN OTHER TIMES (Q 13.C.(4)c = NO), GO TO Q 14.

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_53**

14. INTRODUCTION TO PARTICIPANT: I'm going to ask you about your experiences with the flu vaccine and flu illness during the last flu season, starting in Spring 2009 and ending in Spring 2010.

A flu vaccine is usually given in the fall and protects against influenza for the flu season. Usually, you only need one flu vaccine in the fall to protect against the flu. During this last flu season, an additional flu vaccine was made to protect against the new H1N1 flu virus, so you could have been vaccinated with the regular vaccine, the H1N1 vaccine, or both. If you were given more than one flu vaccine at the same visit by a healthcare provider, you were probably given the regular flu vaccine and the H1N1 flu vaccine. Vaccinations against either flu started about September 2009.

Flu type	a Did you receive a (flu type) vaccine?	b Did you have a flu shot or nose spray for the (flu type)?	c In what month and year did you receive the (flu type) vaccine?	d Where did you get the vaccine for the (flu type)?																		
regular flu	<input type="radio"/> NO <input type="radio"/> YES RFLUV_53 If "NO", go to next row.	Flu shot <input type="radio"/> Nose Spray <input type="radio"/> Both <input type="radio"/> RFTYP_53	<table border="1"> <tr> <td></td> <td>J</td> <td>F</td> <td>M</td> <td></td> <td>S</td> <td>O</td> <td>N</td> <td>D</td> </tr> <tr> <td></td> <td>09</td> <td>10</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> RFLUM_53 RFLUY_53		J	F	M		S	O	N	D		09	10							Specify:
	J	F	M		S	O	N	D														
	09	10																				
H1N1	<input type="radio"/> NO <input type="radio"/> YES H1VAC_53 If "NO", go to Q14.1.	Flu shot <input type="radio"/> Nose Spray <input type="radio"/> Both <input type="radio"/> H1TYP_53	<table border="1"> <tr> <td></td> <td>J</td> <td>F</td> <td>M</td> <td></td> <td>S</td> <td>O</td> <td>N</td> <td>D</td> </tr> <tr> <td></td> <td>09</td> <td>10</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> </tr> </table> H1FLM_53 H1FLY_53		J	F	M		S	O	N	D		09	10							Specify:
	J	F	M		S	O	N	D														
	09	10																				

14.1. The H1N1 flu started making people sick in the spring of 2009 and the regular flu started making people sick in September 2009. Thinking about your flu illness experiences during this time, did you get the "flu"? It can be very difficult to tell the flu from a cold, but in general flu symptoms are much worse and last longer. Common symptoms are fever and sore throat or cough.

- No → **Go to Q 15** **FLUILL_53**
 Yes

14.2. Please tell me about your flu symptoms. If you had the flu more than once, tell me about the time you were most seriously ill with the flu. Did you experience....

	NO	YES	DON'T KNOW
1. Fever	<input type="radio"/>	<input type="radio"/> FLUF_53	<input type="radio"/>
2. Dry cough	<input type="radio"/>	<input type="radio"/> FLUDC_53	<input type="radio"/>
3. Sore throat	<input type="radio"/>	<input type="radio"/> FLUST_53	<input type="radio"/>
4. Muscle or body aches	<input type="radio"/>	<input type="radio"/> FLUMA_53	<input type="radio"/>
5. Nausea, vomiting or diarrhea	<input type="radio"/>	<input type="radio"/> FLUNV_53	<input type="radio"/>
6. Headache	<input type="radio"/>	<input type="radio"/> FLUH_53	<input type="radio"/>

If the participant responds "NO" to all symptoms, GO to Q15.

SERIAL #

14.3. In what month and year did you get the flu? If you had the flu more than once, when were you most seriously sick from the flu?

Month	J	F	M	FLUM_53	S	O	N	D
Year	09	10	FLUY_53					

14.4. How many days did the flu interrupt you from performing your usual daily activities? If you had the flu more than once, how many days did your most serious flu illness interrupt you from your daily activities.

	0	10	FLUDA_53	0	80	90				
	0	1	2	3	4	5	6	7	8	9

Moving on to medications.

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

No Yes → SKIP TO Q 15.A.(1) MAIDS_53

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

READ EACH, MARK ALL THAT APPLY.

- Not infected with HIV → GO TO Q 16 NMNI_53
 - Doctor said was not necessary NMDS_53
 - Not sick NMNS_53
 - Too expensive NMEX_53
 - Don't think they work or will help NMDW_53
 - Possible side effects NMSE_53
 - Can't take them the way the doctor wants (too many times during the day or won't remember to) NMCD_53
 - Other reason NMOR_53
- Specify:

15.A.(1) Since your last visit [in (MONTH, YEAR)], has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs? I am referring to the types of HIV drug resistance tests that are called genotyping or phenotyping.

RESIT_53 No → SKIP TO Q 15.B.(1) IF ON HIV MEDS SINCE LAST VISIT
 Yes → SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT

(2) Has your treatment (drugs) been changed as a result of that test? No RSTCH_53
 Yes
 Don't know

SKIP TO Q 16 IF NOT ON HIV MEDS SINCE LAST VISIT

* 15.B.(1) Since your last visit [in (MONTH, YEAR)], have you taken any medications or drugs on this list [SHOW LIST 1 AND MEDICATION PHOTO CARDS]?

No → SKIP TO Q 15.C. ML1AD_53
 Yes

15.B.(2) Please name those drugs that you have taken or show me which ones.



FILL IN THE BUBBLE NEXT TO THE DRUG(S) AND THEN COMPLETE FORM 1 FOR EACH DRUG.

- abacavir (Ziagen) (218)
- atazanavir (Reyataz) (243)
- Atripla (efavirenz + emtricitabine + tenofovir) (262)
- Combivir (zidovudine + lamivudine) (227)
- d4T (Zerit, Stavudine) (159)
- darunavir (Prezista) (256)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- Epzicom (abacavir + lamivudine) (254)
- Etravirine (Intelence, TMC-125) (255)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- lamivudine (EpiVir, 3TC) (204)
- lopinavir/ritonavir (Kaletra, LPV) (217)
- nelfinavir (Viracept) (216)
- nevirapine (Viramune) (191)
- Raltegravir (Isentress) (264)
- ritonavir (Norvir) (211)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Truvada (emtricitabine + tenofovir) (253)
- zidovudine (Retrovir, AZT) (092)
- Other anti-retroviral from Drug List 1

(Report Acyclovir in Q 16.)

- ML1A1_53
- ML1A2_53
- ML1A3_53
- ML1A4_53
- ML1A5_53
- ML1A6_53
- ML1A7_53
- ML1A8_53
- ML1A9_53
- ML110_53
- ML111_53
- ML112_53

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

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

No → SKIP TO Q 15.C. MDRUG_53
 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

MISTI_53

Did your physician prescribe or agree to any of these? No Yes PDRUG_53

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

DDRUG_53

16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)	a How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	b When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?	c Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?																																														
IF "NO" TO a GO TO NEXT ITEM	NO YES	Name:	NO YES																																														
6) Medication taken by mouth for worms or parasites	WRMDV_53	Name:	WRMD5_53																																														
7) Tranquilizers or sleeping pills	TRNQV_53	Name:	TRNQ5_53																																														
8) Antidepressants or mood elevators	MOODV_53	Name:	MOOD5_53																																														
9) Lithium	LITHV_53	Name:	LITH5_53																																														
10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it: Everyday? <input type="radio"/> No <input type="radio"/> Yes Only when you had active lesions or had an outbreak? <input type="radio"/> No <input type="radio"/> Yes	ACYCV_53 CHACY_53 EPACY_53	Name:	ACYC5_53																																														
11) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	VIAGR_53	Name:	VIAG5_53																																														
12) Aspirin taken three days or more on a weekly basis	ASPRN_53	Name:	ASPR7_53																																														
13) Medications to lower cholesterol, triglycerides, lipids or blood fat a. <table border="1" data-bbox="357 1226 746 1352"> <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 colspan="7">CHDGG1_53</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	CHDGG1_53							800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	CHOL1_53 SKIP TO Q 16.14	Name:	CHL15_53	
	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																							
	0	100	CHDGG1_53							800	900																																						
	0	10	20	30	40	50	60	70	80	90																																							
	0	1	2	3	4	5	6	7	8	9																																							
b. <table border="1" data-bbox="357 1436 746 1562"> <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 colspan="7">CHDGG2_53</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	CHDGG2_53							800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	CHOL2_53 SKIP TO Q 16.14	Name:	CHL25_53	
	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																							
	0	100	CHDGG2_53							800	900																																						
	0	10	20	30	40	50	60	70	80	90																																							
	0	1	2	3	4	5	6	7	8	9																																							
c. <table border="1" data-bbox="357 1646 746 1772"> <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 colspan="7">CHDGG3_53</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	CHDGG3_53							700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	CHOL3_53 SKIP TO Q 16.14	Name:	CHL35_53
	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																							
	0	100	CHDGG3_53							700	800	900																																					
	0	10	20	30	40	50	60	70	80	90																																							
	0	1	2	3	4	5	6	7	8	9																																							

16. Continued

<p>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)</p>	<p>a How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?</p>	<p>b When specified, what was the name of the (KIND OF DRUG) you took?</p>	<p>c Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</p>																																								
<p>IF "NO" TO a GO TO NEXT ITEM</p>	<p>NO YES</p>	<p>Name:</p>	<p>NO YES</p>																																								
<p>14) Medications to treat hypertension</p> <p>a.</p> <table border="1"> <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>100</td><td>200</td><td colspan="4">HTDG1_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200	300	400	500	600	700	800	900	0	100	200	HTDG1_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>HYPT1_53</p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>	<p>HYP15_53</p>
0	100	200	300	400	500	600	700	800	900																																		
0	100	200	HTDG1_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>b.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">HTDG2_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200					700	800	900	0	100	200	HTDG2_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>HYPT2_53</p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>	<p>HYP25_53</p>
0	100	200					700	800	900																																		
0	100	200	HTDG2_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>c.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">HTDG3_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200					700	800	900	0	100	200	HTDG3_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>HYPT3_53</p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>	<p>HYP35_53</p>
0	100	200					700	800	900																																		
0	100	200	HTDG3_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>d.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">HTDG4_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200					700	800	900	0	100	200	HTDG4_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>HYPT4_53</p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>	<p>HYP45_53</p>
0	100	200					700	800	900																																		
0	100	200	HTDG4_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>e.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">HTDG5_53</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>	0	100	200					700	800	900	0	100	200	HTDG5_53				700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<p>HYPT5_53</p> <p>SKIP TO Q 16.15</p>	<p>Name:</p>	<p>HYP55_53</p>
0	100	200					700	800	900																																		
0	100	200	HTDG5_53				700	800	900																																		
0	10	20	30	40	50	60	70	80	90																																		
0	1	2	3	4	5	6	7	8	9																																		
<p>15) Medications to treat diabetes</p> <p>a.</p> <table border="1"> <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>100</td><td>200</td><td colspan="4">DIAT1_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200	300	400	500	600	700	800	900	0	100	200	DIAT1_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>DIAB1_53</p> <p>SKIP TO Q 16.16</p>	<p>Name:</p>	<p>DIA15_53</p>
0	100	200	300	400	500	600	700	800	900																																		
0	100	200	DIAT1_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>b.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">DIAT2_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td colspan="4"></td><td>7</td><td>8</td><td>9</td></tr> </table>	0	100	200					700	800	900	0	100	200	DIAT2_53				700	800	900	0	10	20					70	80	90	0	1	2					7	8	9	<p>DIAB2_53</p> <p>SKIP TO Q 16.16</p>	<p>Name:</p>	<p>DIA25_53</p>
0	100	200					700	800	900																																		
0	100	200	DIAT2_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2					7	8	9																																		
<p>c.</p> <table border="1"> <tr><td>0</td><td>100</td><td>200</td><td colspan="4"></td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>100</td><td>200</td><td colspan="4">DIAT3_53</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td colspan="4"></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>	0	100	200					700	800	900	0	100	200	DIAT3_53				700	800	900	0	10	20					70	80	90	0	1	2	3	4	5	6	7	8	9	<p>DIAB3_53</p> <p>SKIP TO Q 16.16</p>	<p>Name:</p>	<p>DIA35_53</p>
0	100	200					700	800	900																																		
0	100	200	DIAT3_53				700	800	900																																		
0	10	20					70	80	90																																		
0	1	2	3	4	5	6	7	8	9																																		

16. Continued

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. NO YES ODRG6_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG6_53</p>	<p>Used for:</p>	<p>NO YES ODG65_53</p>
<p>g. NO YES ODRG7_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG7_53</p>	<p>Used for:</p>	<p>ODG75_53</p>
<p>h. NO YES ODRG8_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG8_53</p>	<p>Used for:</p>	<p>ODG85_53</p>
<p>i. NO YES ODRG9_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG9_53</p>	<p>Used for:</p>	<p>ODG95_53</p>
<p>j. NO YES ODRG10_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG10_53</p>	<p>Used for:</p>	<p>ODG105_53</p>
<p>k. NO YES ODRG11_53 SKIP TO Q 17.A</p>	<p>Name:</p> <p>DRUG11_53</p>	<p>Used for:</p>	<p>ODG115_53</p>

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_53**
- 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_53**
- Yes - did you have

NO YES

- 1) Coverage by an HMO **HMOC_53**
- 2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) **GPIC_53**
- 3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) **IPIC_53**
- 4) Medicaid, Medi-Cal, or Medical Assistance **MCAID_53**
- 5) Medicare (for people over 65 or permanently disabled) **MCARE_53**
- 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_53**

7) Other (such as Ryan White) **OTHER_53**

Specify:

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

- No **INSDG_53**
- 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_53**
- Yes

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

- No **DINS_53**
- 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	<input type="text"/>	<input type="text"/>
	HMOOV_53		0 10 20	80 90
			<input type="text"/>	<input type="text"/>
			0 1 2	8 9
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care			<input type="text"/>	<input type="text"/>
	DOCOV_53		0 10 20	80 90
			<input type="text"/>	<input type="text"/>
			0 1 2	8 9
3) Any other clinic			<input type="text"/>	<input type="text"/>
	CLOV_53		0 10 20	80 90
			<input type="text"/>	<input type="text"/>
			0 1 2	8 9
4) Emergency room			<input type="text"/>	<input type="text"/>
	EROV_53		0 10 20	80 90
			<input type="text"/>	<input type="text"/>
			0 1 2	8 9
5) Other outpatient service (Specify below)			<input type="text"/>	<input type="text"/>
	OPOV_53		0 10 20	80 90
			<input type="text"/>	<input type="text"/>
			0 1 2	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 GO TO Q 22.A <input type="radio"/> YES		<input type="text"/>	<input type="text"/>
	DENTV_53		0 10 20	70 80 90
			<input type="text"/>	<input type="text"/>
			0 1 2 3 4 5 6 7 8 9	

27.

Abbreviated interview

- No
- Yes

ABINT_53

28.

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	

S4TEH_53
S4TEM_53
S4TEZ_53

29.

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

INTVN_53

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_53

Behavior Section begins here.
Administer by MWII (ACASI)
unless participant actively
requests S4 interview.

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_53

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

- No → **SKIP TO Q 32**
- Yes

FNDIF_53

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

- Less
- Same
- Greater

FNDFL_53

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_53

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

- | | NO | YES |
|--|----|-----------------|
| 1) Became too sick to work | | TSICK_53 |
| 2) HIV status became known to employer | | STKNE_53 |
| 3) HIV status became known to coworkers | | STKNC_53 |
| 4) Early retirement | | RETEY_53 |
| 5) Changed job as a personal decision | | JOBPE_53 |
| 6) To receive better health insurance benefits | | JOBHE_53 |
| 7) To receive better disability benefits | | DISAB_53 |
| 8) Other | | JOBOT_53 |

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_53**
 Yes

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

- No → **SKIP TO Q 34** **SMOKN_53**
 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_53**
 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_53**

- 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_53**

- 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_53**

D. How often during the past 6 months have you found that you were not able to stop drinking once you started? **NSDRK_53**

- Never Monthly Daily or almost daily
 Less than monthly Weekly

E. How often during the past 6 months have you failed to do what was normally expected from you because of drinking? **FLDRK_53**

- Never Monthly Daily or almost daily
 Less than monthly Weekly

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? **MODRNK_53**

- Never Monthly Daily or almost daily
 Less than monthly Weekly

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_53**

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_53**

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

- No **HDRNK_53**
 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_53**
 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_53**

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_53**
 Yes

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

- No → **SKIP TO Q 39** **SEXVF_53**
 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	2	NSEXF_53				0	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 [in (MONTH, YEAR)]?

	0	100	200	300	400	500	600	700	800	900
	0	10	2	NSXAF_53				0	80	90
	0	1	2	3	4	5	6	7	8	9

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? **FPRT1_53**

- 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**

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_53**

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

- No Yes **MPFIV_53**

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

- Negative Positive Don't Know **MPHIVE_53**

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?)
<p>1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).</p>	<p>NO YES OINF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NOINF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>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?</p> <p>IF ONE PARTNER: Did you use a condom <u>every</u> time you had oral sex even if it broke, tore, or slipped?</p>	<p>COIF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NCOIF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>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)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</p>	<p>OEJF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NOEJF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</p>	<p>VINF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NVINF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>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?</p> <p>IF ONE PARTNER: Did you use a condom <u>every</u> time for vaginal sex, even if it broke, tore, or slipped?</p>	<p>CVIF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NCVIF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>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)?</p> <p>IF ONE PARTNER: Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</p>	<p>VEJF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NVEJF_53 0 10 20 0 80 90 0 1 2 0 8 9</p>
<p>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</p>	<p>AINF1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NAINF_53 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9</p>

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_53**

- 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_53**

D. Did you have unprotected anal intercourse with your main partner since your last visit [in (MONTH, YEAR)]? **MPMIV_53**

- No
- Yes

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

- Negative
- Positive
- Don't Know **MPHIVM_53**

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_53	 NOINM_53
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_53	 NCOIM_53
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_53	 NOEJM_53

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_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NAINM_53) 70 80 90 0 1 () 7 8 9</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_53</p> <p>DON'T KNOW/NOT SURE NEG. POS. SURE HIVSTAT1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NCAIM_53) 70 80 90 0 1 () 7 8 9</p> <p>DON'T KNOW/NOT SURE NO YES 5b.1) HPAIM_53 5b.2) HNAIM_53 5b.3) HUAIM_53</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_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NAEJM_53) 70 80 90 0 1 () 7 8 9</p>
<p>7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES ORRC1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NORCM_53) 70 80 90 0 1 () 7 8 9</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>NO YES CORR1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NCORM_53) 70 80 90 0 1 () 7 8 9</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>NO YES OREM1_53</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 (NOREM_53) 70 80 90 0 1 () 7 8 9</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_53	0 100 200 300 400 500 600 700 800 900 NARIM_53
<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 <u>every</u> 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,</p> <p>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 <u>every</u> time, even if it broke, tore, or slipped?</p> <p>If 11a = No,</p> <p>11a.1) What was the HIV status of your partner when he did not use a condom?</p>	<p>NO YES CANR1_53</p> <p>DON'T KNOW/NOT SURE NEG. POS. SURE HIVSTAT2_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NCARM_53</p> <p>11b.1) HPARM_53 11b.2) HNARM_53 11b.3) HUARM_53</p>
<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_53</p>	<p>0 100 200 300 400 500 600 700 800 900 NAREM_53</p>
13) You used your tongue to touch or lick his anus/butt ("rimming").	NO YES RIMI1_53	0 100 200 300 400 500 600 700 800 900 NRMIM_53
14) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).	NO YES DWKS1_53	0 100 200 300 400 500 600 700 800 900 NDWKM_53

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_53
 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_53 | f) in a park or other outdoor public place | NO YES
METOP_53 |
| b) at a party (including a circuit party) | METPY_53 | g) in a bathroom, bookstore, or other indoor public place | METIP_53 |
| c) through an advertisement in a newspaper or other news outlet | METAD_53 | h) at a place where drugs were used or exchanged | METDR_53 |
| d) at a bar | METBAR_53 | i) other place not listed above | METOT_53 |
| e) at a bath house | METBH_53 | | |

SERIAL #

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.]				
		DAILY	WEEKLY	MONTHLY	LESS OFTEN	SNORTED	SWALLOWED	PUT IN ANUS ("booty bumped")	SMOKED	INJECTED (intravenous use)
Pot, Marijuana or Hash	NO YES HASHV_53	<input type="radio"/>	HASHF_53	<input type="radio"/>						
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	POPPV_53	<input type="radio"/>	POPPF_53	<input type="radio"/>						
Crack or cocaine that you smoke	CRACV_53	<input type="radio"/>	CRACF_53	<input type="radio"/>						
Other forms of cocaine	OCOKV_53	<input type="radio"/>	OCOKF_53	<input type="radio"/>		COCSNR_53	COCSWL_53	COCANU_53	COCINJ_53	
Speed, Meth or Ice	UPPRV_53	<input type="radio"/>	UPPRF_53	<input type="radio"/>		SMISNR_53	SMISWL_53	SMIANU_53	SMISMK_53	SMIINJ_53
Heroin	HEROV_53	<input type="radio"/>	HEROF_53	<input type="radio"/>		HERSNR_53	HERSWL_53	HERANU_53	HERSMK_53	HERINJ_53
Speedball (heroin and cocaine together)	SPEBV_53	<input type="radio"/>	SPEBF_53	<input type="radio"/>		SPBSNR_53	SPBSWL_53	SPBANU_53	SPBSMK_53	SPBINJ_53
Ecstasy, XTC, X or MDMA	MDAV_53	<input type="radio"/>	MDAF_53	<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_53	<input type="radio"/>	SEXPF_53	<input type="radio"/>						
Other kinds of street/club drugs	STMDV_53 GO TO Q 43.A									
Specify:	STMD1_53	<input type="radio"/>	ST1DF_53	<input type="radio"/>						
Specify:	STMD2_53	<input type="radio"/>	ST2DF_53	<input type="radio"/>						
Specify:	STMD3_53	<input type="radio"/>	ST3DF_53	<input type="radio"/>						
Specify:	STMD4_53	<input type="radio"/>	ST4DF_53	<input type="radio"/>						
Specify:	STMD5_53	<input type="radio"/>	ST5DF_53	<input type="radio"/>						
Specify:	STMD6_53	<input type="radio"/>	ST6DF_53	<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_53
Yes

B. Do you currently inject drugs?

- No RCDNO_53
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)

0-90 scale for Speedball with TINSB_53 label

Cocaine by itself

0-90 scale for Cocaine by itself with TINCO_53 label

Heroin by itself

0-90 scale for Heroin by itself with TINHO_53 label

Speed by itself

0-90 scale for Speed by itself with TINSO_53 label

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 SHRNW_53
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?

0-90 scale for 45.A with TSHNW_53 label

B. With how many different people?

0-90 scale for 45.B with SHWNP_53 label

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_53
Yes

B. How many times?

0-90 scale for 46.B with TSH2O_53 label

C. With how many different people?

0-90 scale for 46.C with DPH2O_53 label

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

- Never
Less than half the time FBLEA_53
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_53
Yes

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

- Less than half the time HONEP_53
Half the time
Most of the time
Always

C. Do you have another source of clean needles?

- No OSCLN_53
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_53
Yes

Interviewer Instructions:

Thank the participant.

Record the time ended on page 23.

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #