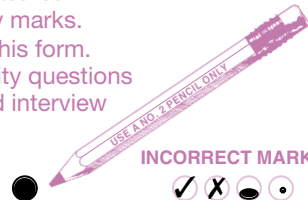


Effective January 18, 2011, the variable visit number suffix was changed from 2 digits (i.e., VARIABLE\_54) to a 3 digit suffix (i.e., VARIABLE\_054) and affects ALL visit questionnaire variables from the first visit onward.

- 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 4 0
0
2
3
4
5
6
7
8
9

VISIT\_054

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

S4TBH\_054  
S4TBM\_054  
S4TBZ\_054

DATE		
MONTH	DAY	YEAR
Jan	1	10
Feb	2	11
Mar	3	12
Apr	4	13
May	5	14
June	6	15
July	7	16
Aug	8	17
Sept	9	18
Oct	10	19
Nov	11	20
Dec	12	21

DATE4M\_054  
DATE4D\_054  
DATE4Y\_054

\* 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 → IF "NO," GO TO Q 2  
 Yes → CANCD\_054

**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: [0 1M 2M 3M 4M 5M 6M 7M 8M 9M] [0 100] CAN1T\_054 [700 800 900]  
Type: [0 10 20 30 40 50 60 70 80 90] [0 1 2 3 4 5 6 7 8 9]

2) Site: [0 1M 2M 3M 4M 5M 6M 7M 8M 9M] [0 100] CAN2T\_054 [700 800 900]  
Type: [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] CAN1M\_054 [A S O N D]  
[00 01] CAN1Y\_054 [7 08 09 10 11]

[J F] CAN2M\_054 [A S O N D]  
[00 01] CAN2Y\_054 [7 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

PLEASE DO NOT WRITE IN THIS AREA



SERIAL #

\* 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  
 Yes  
AID\_054

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="width: 20px;">0</td><td>1M</td><td>2M</td><td>3M</td><td>4M</td><td>5M</td><td>6M</td><td>7M</td><td>8M</td><td>9M</td></tr> <tr><td>0</td><td>100</td><td colspan="6">AIDT1_054</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	1M	2M	3M	4M	5M	6M	7M	8M	9M	0	100	AIDT1_054						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="display: inline-table; vertical-align: top;"> <tr><td style="width: 20px;">J</td><td>F</td><td colspan="4">AIDM1_054</td><td>A</td><td>S</td><td>O</td><td>N</td><td>D</td></tr> <tr><td>00</td><td>01</td><td colspan="4">AIDY1_054</td><td>07</td><td>08</td><td>09</td><td>10</td><td>11</td></tr> </table>	J	F	AIDM1_054				A	S	O	N	D	00	01	AIDY1_054				07	08	09	10	11
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00	01	AIDY2_054				07	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  
 Yes  
PNEUM\_054

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

J	F	MPNEU_054	A	S	O	N	D
00	01	PNEUY_054	07	08	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\_054

SKIP  
TO Q 5

B. IF YES: When was your last test?

Month: J F PPDM\_054 S O N D  
Day: 00 01 PPDY\_054 08 09 10 11

C. Was it positive?

NO YES  
PSPPD\_054

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

TBDXE\_054

GET MEDICAL RELEASE

\* 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\_054

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

0 10 NHOSP\_054 70 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 HOS1M\_054 S O N D  
DAY: 0 10 HOS1D\_054  
YEAR: 0 1 HOS1Y\_054 8 9

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

0 10 HOS1N\_054 80 90  
0 1 2 3 4 5 6 7 8 9 NIGHTS

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

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\_054  
0 1M 2M 3M 4M H1DX1\_054

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) Diagnosis or procedure

V E P TYHO12\_054  
0 1M 2M 3M 4M H1DX2\_054

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

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	HOS2M_054	S	O	N	D					
DAY		0	10	HOS2D_054									
		0	1	HOS2Y_054	8	9							
YEAR		00	01	02	03	04	05	06	07	08	09	10	11

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

	0	10	HOS2N_054	70	80	90
	0	1		7	8	9

NIGHTS

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

**RECORD FULLY IN R's OWN WORDS.**

<p><b>What was the name and address of the physician who diagnosed the condition(s)?</b>  <b>IF AIDS RELATED,</b>  <b>CODE IN QUESTIONS 1-3 AS APPROPRIATE</b></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_054 H2DX1_054</p> <p>0 1M 2M 3M 4M</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_054 H2DX2_054</p> <p>0 1M 2M 3M 4M</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**

Yes **PHOS2\_054**

**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\_054**

Yes

Don't know

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

	J	F	DEPRM_054	S	O	N	D	
	00	01	DEPRY_054	7	08	09	10	11

**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\_054**

Yes

**DOCUMENT ANY NEW NEUROLOGICAL DIAGNOSES IN Q10.CC.i**

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

- No → **GO TO Q 9.B** **APAPS\_054**
- Yes
- Don't Know → **GO TO Q 9.B**

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

	J	F	<b>PAPSM_054</b>	S	O	N	D
	00	01	<b>PAPSY_054</b>	08	09	10	11

(3) Were the results abnormal?

- No → **GO TO Q 9.B** **ABRAP\_054**
- Yes → **GET MEDICAL RELEASE**
- Unable to evaluate/don't know → **GET MEDICAL RELEASE**

Name of the doctor who performed the pap smear and where it was performed.	
Name of doctor	
Name of hospital/center/clinic	
City	State

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\_054**

\* 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\_054**

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

**BIOP\_054**   TIMES

(3) For each biopsy, please tell me:

a Where in your body?	b What did they say the diagnosis or result of the biopsy was?	c Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy.
<p>1) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP1_054</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX1_054</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>
<p>2) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP2_054</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX2_054</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>
<p>3) Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP3_054</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/></p> <p><input type="text" value="0"/> <input type="text" value="1"/> <input type="text" value="2"/> <input type="text" value="3"/> <input type="text" value="4"/> <input type="text" value="5"/> <input type="text" value="6"/> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>Specify:</p> <p>_____</p> <p>_____</p> <p><input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX3_054</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/></p>	<p>_____</p> <p>Name of doctor</p> <p>_____</p> <p>Name of hospital/center/clinic</p> <p>_____</p> <p>City _____ State _____ DATE _____</p>

**GET MEDICAL RELEASE**

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

NO YES

- A. Thrush (yeast in your mouth) **THRSH\_054**
- B. Sinusitis, a sinus infection that requires antibiotics **SINUS\_054**
- C. Bronchitis **BRONC\_054**
- D. Erectile dysfunction (erectile problems) **ERDYS\_054**
- E. High blood pressure or hypertension **HBPHT\_054**
- F. High cholesterol, high triglycerides, high lipids or too much fat in your blood **HCHOL\_054**
- G. High blood sugar or diabetes **HBSUG\_054**
- H. Arthritis **ARTHR\_054**  
 IF YES: Was it: Rheumatoid **RHEUM\_054**  
 (Read and answer each.) Osteoarthritis or degenerative **OSTAR\_054**  
Other **OTHAR\_054**

Specify:

Don't know **DKWAR\_054**

- \*I. Angina or chest pain caused by your heart **ANGIN\_054**
- \*J. Heart attack or myocardial infarction (MI) **HRTAT\_054**
- \*K. Congestive heart failure or CHF **HRTFA\_054**
- \*L. Stroke or Cerebrovascular accident (CVA) **STROK\_054**
- \*M. Mini-strokes or transient ischemic attacks (TIA) **TIA\_054**
- \*N. Too fast, too slow, or irregular heart beat **IRHB\_054**
- \*O. Any blood vessels (arteries) that were blocked or closed IF NO, SKIP TO Q Q **BVES\_054**
- \*P. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas **OBVES\_054**
- \*Q. A blood clot in your legs **BCLG\_054**
- \*R. Kidney disease/Renal failure **KIDND\_054**
- S. An elevated liver enzyme **LIVDE\_054**

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

Name of hospital/clinic or doctor

Address

City State

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 **BBONE30\_054**

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	<b>BB30S1A_054</b>							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	<b>BB30S1B_054</b>							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

**BB30AGE1\_054**

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 **BB30HOW1\_054**
- Don't know

**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	<b>BB30S2A_054</b>							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	<b>BB30S2B_054</b>							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

**BB30AGE2\_054**

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 **BB30HOW2\_054**
- 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	BB30S3A_054							0	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	BB30S3B_054							0	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	BB30AGE3_054							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 **BB30HOW3\_054**
- 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	BB30S4A_054							0	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	BB30S4B_054							0	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	BB30AGE4_054							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 **BB30HOW4\_054**
- 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	BB30S5A_054							0	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	BB30S5B_054							0	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	BB30AGE5_054							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 **BB30HOW5\_054**
- Don't know

- More than 5 diagnosed fracture incidents **BB30MORE\_054**

<b>What was the name and address of the physician who diagnosed the condition(s)?</b>
_____
Name of hospital/clinic or doctor
_____
Address
_____
City
_____
State



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  
**VIDEY\_054**  
**EYDIA\_054**

SKIP  
TO  
b

Specify:

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

b) Ears, Nose, Throat, Mouth and Sinuses

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

NO YES  
**VIDNO\_054**  
**ENDIA\_054**

SKIP  
TO  
c

Specify:

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

c) Heart and Blood Vessels

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

NO YES  
**VIDHT\_054**

**GET MEDICAL RELEASE**

SKIP  
TO  
d

Specify:

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

d) Lungs and Bronchial Tubes

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

NO YES  
**VIDLG\_054**  
**LGDIA\_054**

SKIP  
TO  
e

Specify:

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

e) Stomach, Intestines, or Liver Disease

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

NO YES  
**VIDSL\_054**  
**SLDIA\_054**

SKIP  
TO  
f

Specify:

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

f) Bones, Joints or Muscles

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

NO YES  
**VIDBJ\_054**  
**BJDIA\_054**

SKIP  
TO  
g

IF OSTEOPOROSIS, AVASCULAR NECROSIS OR OSTEONECROSIS, GET MEDICAL RELEASE.

Specify:

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

g) Genital, Urinary and Rectal

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

NO YES  
**VIDGU\_054**  
**GUDIA\_054**

SKIP  
TO  
h

Specify:

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

h) Skin

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

NO YES  
**VIDSK\_054**  
**SKDIA\_054**

SKIP  
TO  
i

Specify:

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

i) Nervous system problems involving any part of the body

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

**GET MEDICAL RELEASE**

NO YES  
**VIDNS\_054**

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

**NSDIA\_054**

SKIP  
TO  
j

Specify:

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

**SERIAL #**

CC. Continued

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

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

NO YES

VIDPY\_054  
PYDIA\_054

SKIP TO k

Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	10	PYCON_054						100	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

k) Hormones or Endocrine system

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

NO YES

VIDHO\_054  
HODIA\_054

SKIP TO l

Specify:

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M	
	0	HOCON_054								100	900
	0	10	20	30	40	50	60	70	80	90	
	0	1	2	3	4	5	6	7	8	9	

l) Other

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

NO YES

VIDO\_054  
ODIA\_054

SKIP TO Q11.A

1.

	0	1M	2M	3M	4M	5M	6M	7M	8M	9M
	0	OCON1_054								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	OCON2_054								70
	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

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\_054**
- 2) Sores in genital region **HERPG\_054**
- 3) Sores in the anal or rectal areas **HERPA\_054**
- 4) Sores elsewhere on your body **HERPE\_054**

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\_054**

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\_054**

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
----------------------	-------------

A.1) Syphilis

NO YES  
**SYPHA\_054**

IF "NO," SKIP TO (B)

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

- New infection **SYPHN\_054**
- Continued or relapse

B) Any form of gonorrhea

**GONOR\_054**

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

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

**UGONA\_054**

D) Oral gonorrhea (of the mouth or throat)

**OGONA\_054**

E) Rectal gonorrhea (of the rectum)

**RGONA\_054**

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

**URETC\_054**

G.1) Genital warts (condylomata acuminata)

**WARTG\_054**

IF "NO," SKIP TO (H)

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

- New infection **WRTGN\_054**
- Continued or relapse

H.1) Anal warts (condylomata acuminata)

**WARTS\_054**

IF "NO," SKIP TO Q13.A

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

- New infection **WRTSN\_054**
- Continued or relapse

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_054		DIZ2W_054		DIZNO_054		DZMED_054			DIZNC_054	
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	FATIG_054		FAT2W_054		FATIN_054		FTMED_054			FATNC_054	
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	FEVER_054		FEV2W_054		FEVRN_054		FVMED_054			FEVNC_054	
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	HEADA_054		HED2W_054		HEADN_054		HDMED_054			HEANC_054	
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	RASH_054		RAS2W_054		RASHN_054		RHMED_054			RSHNC_054	
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	GLAND_054		GLN2W_054		GLANN_054		GLMED_054			GLANC_054	
7) Diarrhea for at least 3 consecutive days	DIARR_054		DIA2W_054		DIARN_054		DIMED_054			DIANC_054	
8) Drenching sweats at night on at least 3 occasions	SWEAT_054		SWT2W_054		SWETN_054		SWMED_054			SWENC_054	
9) Nausea, vomiting	VOMIT_054		VOT2W_054		VOTNO_054		VTMED_054			VOTNC_054	
10) Abdominal pain, bloating, cramps	BLOAT_054		ABP2W_054		ABPNO_054		ABMED_054			ABPNC_054	
11) Ascites (fluid buildup in the stomach or abdomen)	ASCIT_054		ASC2W_054		ASCNO_054		ASMED_054			ASCNC_054	
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	JDICE_054		JDI2W_054		JDINO_054		JDMED_054			JDINC_054	
13) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	WTLOS_054				WTLSN_054		WTMED_054			WTLNC_054	
14) Muscle pain or weakness	MPAIN_054		MPW2W_054		MPWNO_054		MPMED_054			MPWNC_054	
	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

SERIAL #

13.A. Continued

PROBLEM OR SYMPTOM  FOR EACH "YES" IN <u>a</u> , ASK <u>b</u> , <u>c</u> , <u>d</u> , AND <u>e</u> .	<u>a</u>		<u>b</u>		<u>c</u>		<u>d</u>			<u>e</u>	
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES
15) Joint pain	JOINT_054		JNT2W_054		JNTNO_054		JTMED_054			JNTNC_054	
16) Vivid nightmares or dreams	DREAM_054		NVD2W_054		NVDNO_054		DRMED_054			NVDNC_054	
17) Insomnia or problems sleeping	INSOM_054		IPS2W_054		IPSNO_054		INMED_054			IPSNC_054	
18) Persistent dry mouth	DRYMO_054		DRY2W_054		DRYNO_054		DMMED_054			DRYNC_054	

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

	If NO, go to next question. If YES, indicate severity.				Severity (0= None, 1= Mild, 10= Severe)		Did you experience this symptom due to taking any medication?			
	NO	YES					NO	YES	DON'T KNOW	
1. Pain, aching, or burning in your feet or legs?	FEETP_054 →		Right	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	PAINR_054	<input type="text"/> <input type="text"/> <input type="text"/>	PLMED_054		
			Left	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	PAINL_054	<input type="text"/> <input type="text"/> <input type="text"/>			
2. Pins and needles in your feet or legs?	PINSF_054 →		Right	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	PINSR_054	<input type="text"/> <input type="text"/> <input type="text"/>	PIMED_054		
			Left	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	PINSL_054	<input type="text"/> <input type="text"/> <input type="text"/>			
3. Numbness (lack of feeling) in your feet or legs?	NUMBF_054 →		Right	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	NUMBR_054	<input type="text"/> <input type="text"/> <input type="text"/>	NBMED_054		
			Left	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	NUMBL_054	<input type="text"/> <input type="text"/> <input type="text"/>			

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 15**  
 Yes **ANBLD\_054**

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\_054**

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\_054**

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

[READ EACH ITEM]

	NO	YES
a) After or during anal receptive intercourse	<b>ANBSX_054</b>	
b) After or during a bowel movement	<b>ANBBM_054</b>	
c) Other times not associated with intercourse or bowel movements	<b>ANBOT_054</b>	

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

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

- Daily    Weekly    Monthly    Less than monthly

**ANBOTF\_054**





16. Continued

<p><b>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)</b></p>	<p><b>a</b> How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?</p>	<p><b>b</b> When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?</p>	<p><b>c</b> Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</p>																																												
<p>IF "NO" TO <b>a</b> GO TO NEXT ITEM</p>	<p>NO YES</p>	<p>Name:</p>	<p>NO YES</p>																																												
<p>5) Tranquilizers or sleeping pills</p>	<p>TRNQV_054</p>	<p>Name:</p>	<p>TRNQ5_054</p>																																												
<p>6) Antidepressants or mood elevators</p>	<p>MOODV_054</p>	<p>Name:</p>	<p>MOOD5_054</p>																																												
<p>7) Lithium</p>	<p>LITHV_054</p>	<p>Name:</p>	<p>LITH5_054</p>																																												
<p>8) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it:</p> <p>Everyday? <input type="radio"/> CHACY_054 Only when you had active lesions or had an outbreak? <input checked="" type="radio"/> EPACY_054</p>	<p>ACYCV_054</p>	<p>Name:</p>	<p>ACYC5_054</p>																																												
<p>9) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction</p>	<p>VIAGR_054</p>	<p>Name:</p>	<p>VIAG5_054</p>																																												
<p>10) Aspirin taken three days or more on a weekly basis</p>	<p>ASPRN_054</p>	<p>Name:</p>	<p>ASPR7_054</p>																																												
<p>11) Medications to lower cholesterol, triglycerides, lipids or blood fat</p> <p>a. <table border="1" data-bbox="357 1094 746 1224"> <tr><td></td><td>0</td><td>1000</td><td>2000</td><td>3000</td><td>4000</td><td>5000</td><td>6000</td><td>7000</td><td>8000</td><td>9000</td></tr> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> CHDG1_054</p>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100	200	300	400	500	600	700	800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>CHOL1_054</p>	<p>Name:</p>	<p>CHL15_054</p>
	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																					
	0	100	200	300	400	500	600	700	800	900																																					
	0	10	20	30	40	50	60	70	80	90																																					
	0	1	2	3	4	5	6	7	8	9																																					
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	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																					
	0	100							800	900																																					
	0	10	20	30	40	50	60	70	80	90																																					
	0	1	2	3	4	5	6	7	8	9																																					
<p>c. <table border="1" data-bbox="357 1514 746 1644"> <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></td><td></td><td></td><td></td><td></td><td></td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>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> CHDG3_054</p>		0	1000	2000	3000	4000	5000	6000	7000	8000	9000		0	100							800	900		0	10	20	30	40	50	60	70	80	90		0	1	2	3	4	5	6	7	8	9	<p>CHOL3_054</p> <p>SKIP TO Q 16.12</p>	<p>Name:</p>	<p>CHL35_054</p>
	0	1000	2000	3000	4000	5000	6000	7000	8000	9000																																					
	0	100							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><b>ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG (ITEM 17a)</b></p>	<p><b>a</b> How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?</p>	<p><b>b</b> When specified, what was the name of the (KIND OF DRUG) you took?</p>	<p><b>c</b> Have you taken/used any in the past 5 days (FOR ASPIRIN: in the last week)?</p>																																								
<p>IF "NO" TO <b>a</b> GO TO NEXT ITEM</p>	<p>NO YES</p>	<p>Name:</p>	<p>NO YES</p>																																								
<p><b>12) Medications to treat hypertension</b></p> <p>a.</p> <table border="1"> <tr><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>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td>0</td><td>10</td><td>20</td><td>30</td><td>40</td><td>50</td><td>60</td><td>70</td><td>80</td><td>90</td></tr> <tr><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table> <p>HTDG1_054</p>	0	1000	2000	3000	4000	5000	6000	7000	8000	9000	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<p><b>HYPT1_054</b></p> <p>SKIP TO Q 16.13</p>	<p>Name:</p>	<p><b>HYP15_054</b></p>
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<p><b>13) Medications to treat diabetes</b></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>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> <p>DIAT1_054</p>	0	100	200	300	400	500	600	700	800	900	0	10	20	30	40	50	60	70	80	90	0	1	2	3	4	5	6	7	8	9	<p><b>DIAB1_054</b></p> <p>SKIP TO Q 16.14</p>	<p>Name:</p>	<p><b>DIA15_054</b></p>										
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0	1	2	3	4	5	6	7	8	9																																		



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>15) Other</p> <p>NO YES</p> <p>f. <b>ODRG6_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG6_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p>NO YES</p> <p><b>ODG65_054</b></p>
<p>NO YES</p> <p>g. <b>ODRG7_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG7_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p><b>ODG75_054</b></p>
<p>NO YES</p> <p>h. <b>ODRG8_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG8_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p><b>ODG85_054</b></p>
<p>NO YES</p> <p>i. <b>ODRG9_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG9_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p><b>ODG95_054</b></p>
<p>NO YES</p> <p>j. <b>ODRG10_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG10_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p><b>ODG105_054</b></p>
<p>NO YES</p> <p>k. <b>ODRG11_054</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000</p> <p><input type="text"/> 0 100 200 <b>DRUG11_054</b> 800 900</p> <p><input type="text"/> 0 10 20 30 40 50 60 70 80 90</p> <p><input type="text"/> 0 1 2 3 4 5 6 7 8 9</p>	<p>Used for:</p> <p><input type="text"/></p>	<p><b>ODG115_054</b></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\_054**
- 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\_054**
- Yes - did you have

NO YES

- 1) Coverage by an HMO **HMOC\_054**
- 2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) **GPIC\_054**
- 3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) **IPIC\_054**
- 4) Medicaid, Medi-Cal, or Medical Assistance **MCAID\_054**
- 5) Medicare (for people over 65 or permanently disabled) **MCARE\_054**
- 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\_054**

7) Other (such as Ryan White) **OTHER\_054**

Specify:

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

- No **INSDG\_054**
- 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\_054**
- Yes

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

- No **DINS\_054**
- 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"/>
	<b>HMOOV_054</b>		<input type="text"/> 0 10 20 <input type="text"/> 0 1 2	<b>HMONU_054</b> <input type="text"/> 80 90 <input type="text"/> 8 9
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care			<input type="text"/>	<input type="text"/>
	<b>DOCOV_054</b>		<input type="text"/> 0 10 20 <input type="text"/> 0 1 2	<b>DOCNU_054</b> <input type="text"/> 80 90 <input type="text"/> 8 9
3) Any other clinic			<input type="text"/>	<input type="text"/>
	<b>CLOV_054</b>		<input type="text"/> 0 10 20 <input type="text"/> 0 1 2	<b>CLNUM_054</b> <input type="text"/> 80 90 <input type="text"/> 8 9
4) Emergency room			<input type="text"/>	<input type="text"/>
	<b>EROV_054</b>		<input type="text"/> 0 10 20 <input type="text"/> 0 1 2	<b>ERNUM_054</b> <input type="text"/> 80 90 <input type="text"/> 8 9
5) Other outpatient service (Specify below)			<input type="text"/>	<input type="text"/>
	<b>OPOV_054</b>		<input type="text"/> 0 10 20 <input type="text"/> 0 1 2	<b>OPNUM_054</b> <input type="text"/> 80 90 <input type="text"/> 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="text"/>	<input type="text"/>
	<input type="radio"/>	YES	<input type="text"/> 0 10 20 30 40 50 60 70 <input type="text"/> 0 1 2 3 4 5 6 7	<b>DHNUM_054</b> <input type="text"/> 80 90 <input type="text"/> 8 9



27.

**Abbreviated interview**

**ABINT\_054**

- No
- Yes

28.

\_\_\_\_\_

Date interview completed

TIME ENDED			
HR	MIN		
<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0	<input type="radio"/> 0
<input type="radio"/> 10	<input type="radio"/> 1	<input type="radio"/> 10	<input type="radio"/> 1
<input type="radio"/> 2	<input type="radio"/> 20	<input type="radio"/> 2	<input type="radio"/>
<input type="radio"/> 3	<input type="radio"/> 30	<input type="radio"/> 3	<input type="radio"/>
<input type="radio"/> 4	<input type="radio"/> 40	<input type="radio"/> 4	<input type="radio"/>
<input type="radio"/> 5	<input type="radio"/> 50	<input type="radio"/> 5	<input type="radio"/>
<input type="radio"/> 6	<input type="radio"/> 6	<input type="radio"/> 6	<input type="radio"/>
<input type="radio"/> 7	<input type="radio"/> 7	<input type="radio"/> 7	<input type="radio"/>
<input type="radio"/> 8	<input type="radio"/> 8	<input type="radio"/> 8	<input type="radio"/>
<input type="radio"/> 9	<input type="radio"/> 9	<input type="radio"/> 9	<input type="radio"/>

**S4TEH\_054**  
**S4TEM\_054**  
**S4TEZ\_054**

29.

\_\_\_\_\_

Interviewer's signature

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

**INTVN\_054**

CLINIC IDENTIFIERS	
<input type="radio"/> BA Moore clinic	<b>CLNID_054</b>
<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	

**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\_054**

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

- No → **SKIP TO Q 32**
- Yes

**FNDIF\_054**

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

- Less
- Same
- Greater

**FNDFL\_054**

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\_054**

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

NO YES

- 1) Became too sick to work **TSICK\_054**
- 2) HIV status became known to employer **STKNE\_054**
- 3) HIV status became known to coworkers **STKNC\_054**
- 4) Early retirement **RETEY\_054**
- 5) Changed job as a personal decision **JOBPE\_054**
- 6) To receive better health insurance benefits **JOBHE\_054**
- 7) To receive better disability benefits **DISAB\_054**
- 8) Other **JOBOT\_054**

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\_054**  
 Yes

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

- No → **SKIP TO Q 34** **SMOKN\_054**  
 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\_054**  
 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?

- Never → **STOP - SKIP TO Q 34K** **FADRNK\_054**  
 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.)

- 1 or 2  5 or 6  10 or more  
 3 or 4  7 to 9  None **NADRNK\_054**

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\_054**

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\_054**

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\_054**  
 Yes

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

- No → **SKIP TO Q 39** **SEXVF\_054**  
 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	NSEXF_054				70	80	90	
	0	1	2	3	4	5	6	7	8	9

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

	0	100	200	300	400	500	600	700	800	900
	0	10	NSXAF_054				70	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\_054

- 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\_054

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

- No       Yes      MPFIV\_054

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

- Negative       Positive       Don't Know      MPHIV\_054

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_054</p>	<p>NOINF_054</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_054</p>	<p>NCOIF_054</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_054</p>	<p>NOEJF_054</p>
<p>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</p>	<p>VINF1_054</p>	<p>NVINF_054</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_054</p>	<p>NCVIF_054</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_054</p>	<p>NVEJF_054</p>
<p>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</p>	<p>AINF1_054</p>	<p>NAINF_054</p>

38. Continued

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
<p><b>IF MULTIPLE PARTNERS:</b>                      8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p> <p><b>IF ONE PARTNER:</b>                      Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</p>	<p>NO YES                      CAIF1_054</p>	<p>NCAIF_054</p>
<p><b>IF MULTIPLE PARTNERS:</b>                      9) With how many women did you ejaculate/cum in their anus/butt when you did not use a condom (or when a condom failed)?</p> <p><b>IF ONE PARTNER:</b>                      Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>AEJF1_054</p>	<p>NAEJF_054</p>
<p>10) You used your tongue to touch or lick her anus/butt ("rimming").</p>	<p>RIMF1_054</p>	<p>NRIMF_054</p>
<p>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</p>	<p>LICF1_054</p>	<p>NLICF_054</p>
<p>12) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).</p>	<p>DWKW1_054</p>	<p>NDWKW_054</p>

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

No → **SKIP TO Q 41.15** SEXVM\_054  
 Yes  
 ↓

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

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

NSEXM\_054

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

NNSXM\_054

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

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

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\_054**

- 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\_054**

D. Did you have unprotected anal intercourse with your main partner since your last visit [in (MONTH, YEAR)]? **MPMIV\_054**

- No
- Yes

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

- Negative
- Positive
- Don't Know **MPHIVM\_054**

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 <b>ORIN1_054</b>	 <b>NOINM_054</b>
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?	<b>COIN1_054</b>	 <b>NCOIM_054</b>
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)?	<b>OEJM1_054</b>	 <b>NOEJM_054</b>

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_054</p>	<p>NAINM_054</p>
<p><b>IF MULTIPLE PARTNERS:</b> 5b.) Thinking of the times you put your penis in their anus/butt, with how many of those men did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p><b>If any unprotected anal sex (Q5b &lt; Q4) then read:</b> 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? <b>If 5b.1 or 5b.2 = Don't Know/Not Sure, skip to 6b.</b> 5b.3) Were you unsure of the HIV status of any of these men?</p> <p><b>IF ONE PARTNER:</b> 5a.) Thinking of the times you put your penis in his anus/butt, did you use a condom <u>every</u> time, even if it broke, tore, or slipped?</p> <p><b>If 5a = No,</b> 5a.1) What was the HIV status of your partner when you did not use a condom?</p>	<p>CAIN1_054</p> <p>HIVSTAT1_054</p>	<p>NCAIM_054</p> <p>HPAIM_054 HNAIM_054 HUAIM_054</p>
<p><b>IF MULTIPLE PARTNERS:</b> 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><b>IF ONE PARTNER:</b> 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_054</p>	<p>NAEJM_054</p>
<p>7) He put his penis in your mouth. IF NONE, SKIP TO ITEM (10).</p>	<p>NO YES ORRC1_054</p>	<p>NORCM_054</p>
<p><b>IF MULTIPLE PARTNERS:</b> 8) Thinking of the times when a man put his penis in your mouth, with how many of those men was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p> <p><b>IF ONE PARTNER:</b> Thinking of the times when he put his penis in your mouth, was a condom used <u>every</u> time, even if it broke, tore, or slipped?</p>	<p>CORR1_054</p>	<p>NCORM_054</p>
<p><b>IF MULTIPLE PARTNERS:</b> 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><b>IF ONE PARTNER:</b> Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</p>	<p>OREM1_054</p>	<p>NOREM_054</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?)
<p>10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).</p>	<p>NO YES ANRC1_054</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 NARIM_054 80 90 0 1 2 8 9</p>
<p><b>IF MULTIPLE PARTNERS:</b>            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><b>If any unprotected anal sex (Q11b &lt; Q10) then read:</b>            Of the men who did not use a condom,            11b.1) Were any of these men HIV positive?            11b.2) Were any of these men HIV negative?  <b>If 11b.1 or 11b.2 = Don't Know/Not Sure, skip to 12b.</b>            11b.3) Were you unsure of the HIV status of any of these men?</p> <p><b>IF ONE PARTNER:</b>            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><b>If 11a = No,</b>            11a.1) What was the HIV status of your partner when he did not use a condom?</p>	<p>NO YES CANR1_054</p> <p>DON'T KNOW/NOT SURE            NEG. POS. SURE            HIVSTAT2_054</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 NCARM_054 80 90 0 1 2 3 4 5 6 7 8 9</p> <p>DON'T KNOW/NOT SURE            NO YES            11b.1) HPARM_054            11b.2) HNARM_054            11b.3) HUARM_054</p>
<p><b>IF MULTIPLE PARTNERS:</b>            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><b>IF ONE PARTNER:</b>            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_054</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 NAREM_054 80 90 0 1 2 3 4 5 6 7 8 9</p>
<p>13) You used your tongue to touch or lick his anus/butt ("rimming").</p>	<p>NO YES RIM1_054</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 NRMIM_054 80 90 0 1 2 8 9</p>
<p>14) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).</p>	<p>NO YES DWKS1_054</p>	<p>0 100 200 300 400 500 600 700 800 900 0 10 20 NDWKM_054 80 90 0 1 2 3 4 5 6 7 8 9</p>

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**  
 Yes

**METNW\_054**

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?

	NO	YES		NO	YES
a) on the internet		<b>METIN_054</b>	f) in a park or other outdoor public place		<b>METOP_054</b>
b) at a party (including a circuit party)		<b>METPY_054</b>	g) in a bathroom, bookstore, or other indoor public place		<b>METIP_054</b>
c) through an advertisement in a newspaper or other news outlet		<b>METAD_054</b>	h) at a place where drugs were used or exchanged		<b>METDR_054</b>
d) at a bar		<b>METBAR_054</b>	i) other place not listed above		<b>METOT_054</b>
e) at a bath house		<b>METBH_054</b>			

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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)]? NO YES	b How often did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]? DAILY WEEKLY MONTHLY LESS OFTEN				c How did you (use/take) (DRUG) since your last visit [in (MONTH, YEAR)]? [Mark all that apply.] SNORTED SWALLOWED PUT IN ANUS ("booty bumped") SMOKED INJECTED (intravenous use)				
		Pot, Marijuana or Hash	HASHV_054	<input type="radio"/>	HASHF_054	<input type="radio"/>				
"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)	POPPV_054	<input type="radio"/>	POPPF_054	<input type="radio"/>						
Crack or cocaine that you smoke	CRACV_054	<input type="radio"/>	CRACF_054	<input type="radio"/>						
Other forms of cocaine	OCOKV_054	<input type="radio"/>	OCOKF_054	<input type="radio"/>	COCSNR_054	COCSWL_054	COCANU_054	COCINJ_054		
Speed, Meth or Ice	UPPRV_054	<input type="radio"/>	UPPRF_054	<input type="radio"/>	SMISNR_054	SMISWL_054	SMIANU_054	SMISMK_054	SMIINJ_054	
Heroin	HEROV_054	<input type="radio"/>	HEROF_054	<input type="radio"/>	HERSNR_054	HERSWL_054	HERANU_054	HERSMK_054	HERINJ_054	
Speedball (heroin and cocaine together)	SPEBV_054	<input type="radio"/>	SPEBF_054	<input type="radio"/>	SPBSNR_054	SPBSWL_054	SPBANU_054	SPBSMK_054	SPBINJ_054	
Ecstasy, XTC, X or MDMA	MDAV_054	<input type="radio"/>	MDAF_054	<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.)	SEXP_054	<input type="radio"/>	SEXPO_054	<input type="radio"/>						
Other kinds of street/club drugs	STMDV_054 GO TO Q 43.A									
Specify:	<input type="text"/>	<input type="radio"/>	STMD1_054	ST1DF_054	<input type="radio"/>					
Specify:	<input type="text"/>	<input type="radio"/>	STMD2_054	ST2DF_054	<input type="radio"/>					
Specify:	<input type="text"/>	<input type="radio"/>	STMD3_054	ST3DF_054	<input type="radio"/>					
Specify:	<input type="text"/>	<input type="radio"/>	STMD4_054	ST4DF_054	<input type="radio"/>					
Specify:	<input type="text"/>	<input type="radio"/>	STMD5_054	ST5DF_054	<input type="radio"/>					
Specify:	<input type="text"/>	<input type="radio"/>	STMD6_054	ST6DF_054	<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\_054
Yes

B. Do you currently inject drugs?

- No RCDNO\_054
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\_054 label

Cocaine by itself

0-90 scale for Cocaine by itself with TINCO\_054 label

Heroin by itself

0-90 scale for Heroin by itself with TINHO\_054 label

Speed by itself

0-90 scale for Speed by itself with TINSO\_054 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 SKIP TO Q 46 SHRNW\_054
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\_054 label

B. With how many different people?

0-90 scale for B with SHWNP\_054 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\_054
Yes

B. How many times?

0-90 scale for B with TSH2O\_054 label

C. With how many different people?

0-90 scale for C with DPH2O\_054 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\_054
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\_054
Yes

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

- Less than half the time HONEP\_054
Half the time
Most of the time
Always

C. Do you have another source of clean needles?

- No OSCLN\_054
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\_054
Yes

Interviewer Instructions:

Thank the participant.

Record the time ended on page 23.

PLEASE DO NOT WRITE IN THIS AREA



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