

MARKING INSTRUCTIONS

- 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	VISIT NO.	TIME BEGAN		DATE		
		HR	MIN	MONTH	DAY	YEAR
MACSID 0 0 0 0 1 1 1 1 1 1 2 2 2 2 2 2 3 3 3 3 3 3 4 4 4 4 4 4 5 5 5 5 5 5 6 6 6 6 6 6 7 7 7 7 7 7 8 8 8 8 8 8 9 9 9 9 9 9	5 7 0 0 1 1 2 2 VISIT_057 4 4 5 5 6 6 7 8 8 9 9					
		S4TBH_057 S4TBM_057 S4TBZ_057	3 30 3 4 40 4 5 50 5 6 7 8 9	PM	0 0 09 DAT4M_057 DAT4D_057 DAT4Y_057 4 13 5 14 6 15 7 16 8 17 9 18	

\* 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\_057

a	IF YES: Where in the body was the cancer (Castleman's disease) and what kind of cancer did they say it was?	b	In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?
1)	Site Type 0 1M 2M 3M 4M 5M 6M 7M 8M 9M 0 100 200 300 400 500 600 700 800 900 CAN1_057 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	J F M 01 02 03 CAN1M_057 CAN1Y_057	S O N D 09 10 11 12
2)	Site Type 0 1M 2M 3M 4M 5M 6M 7M 8M 9M 0 100 200 300 400 500 600 700 800 900 CAN2_057 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9	J F M 01 02 03 CAN2M_057 CAN2Y_057	S O N D 09 10 11 12

c

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

\_\_\_\_\_  
Name of hospital/clinic or doctor

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Date

c

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

\_\_\_\_\_  
Name of hospital/clinic or doctor

\_\_\_\_\_  
Address

\_\_\_\_\_  
City State Date

GET MEDICAL RELEASE

3/8" spine perf

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\_057**

<b>a IF YES: What was the diagnosis?</b> (SEE APPENDIX 7 IN GUIDELINES FOR LIST OF AIDS DIAGNOSES.)		<b>b In what month and year was it first diagnosed since your last visit [in (MONTH, YEAR)]?</b>																																																										
1) Type <input type="text"/> <input type="text"/>	<input type="text"/> <table border="1"> <tr><td>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>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>	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	<input type="text"/> <table border="1"> <tr><td>J</td><td>F</td><td>M</td><td>A</td><td><b>AIDM1_057</b></td><td>O</td><td>N</td><td>D</td></tr> <tr><td>01</td><td>02</td><td>03</td><td>04</td><td><b>AIDY1_057</b></td><td>9</td><td>10</td><td>11</td><td>12</td></tr> </table>	J	F	M	A	<b>AIDM1_057</b>	O	N	D	01	02	03	04	<b>AIDY1_057</b>	9	10	11	12	<b>AIDT1_057</b>
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	A	<b>AIDM1_057</b>	O	N	D																																																					
01	02	03	04	<b>AIDY1_057</b>	9	10	11	12																																																				
2) Type <input type="text"/> <input type="text"/>	<input type="text"/> <table border="1"> <tr><td>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>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>	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	<input type="text"/> <table border="1"> <tr><td>J</td><td>F</td><td>M</td><td>A</td><td><b>AIDM2_057</b></td><td>O</td><td>N</td><td>D</td></tr> <tr><td>01</td><td>02</td><td>03</td><td>04</td><td><b>AIDY2_057</b></td><td>9</td><td>10</td><td>11</td><td>12</td></tr> </table>	J	F	M	A	<b>AIDM2_057</b>	O	N	D	01	02	03	04	<b>AIDY2_057</b>	9	10	11	12	<b>AIDT2_057</b>
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	A	<b>AIDM2_057</b>	O	N	D																																																					
01	02	03	04	<b>AIDY2_057</b>	9	10	11	12																																																				

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

\_\_\_\_\_  
 Name of hospital/clinic or doctor

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State Date

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

\_\_\_\_\_  
 Name of hospital/clinic or doctor

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State Date

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

No → IF "NO," GO TO Q 4  
 Yes  
**PNEUM\_057**

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

J	F	M	A	<b>MPNEU_057</b>	O	N	D
01	02	03	04	<b>PNEUY_057</b>	10	11	12

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

\_\_\_\_\_  
 Name of hospital/clinic or doctor

\_\_\_\_\_  
 Address

\_\_\_\_\_  
 City State Date

**Clinician's Notes: Method of Diagnosis**

GET MEDICAL RELEASE

3/8" spine perf

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\_057

SKIP TO Q 5

B. IF YES: When was your last test?

J F P P D M \_ 0 5 7 A S O N D  
0 1 0 2 0 7 0 8 0 9 1 0 1 1 1 2

C. Was it positive?

NO YES  
PSPPD\_057

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

NO YES  
TBDXE\_057

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\_057

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

0 1 3 0 7 0 8 0 9  
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 1 HOS1M\_057  
0 1 HOS1D\_057  
0 1 HOS1Y\_057 7 8 9  
YEAR 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 1 0 1 1 1 2

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

0 6 0 7 0 8 0 9  
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

Date

1) Diagnosis or procedure

Bubble in leading zero  
V E P TYHO11\_057

0 100 200 300 400 500 600 700 800 900

0 10 20 H1DX1\_057 80 90

0 1 2 3 4 5 6 7 8 9

0 1 2 3 4 5 6 7 8 9

2) Diagnosis or procedure

V E P TYHO12\_057

0 100 200 300 400 500 600 700 800 900

0 10 20 H1DX2\_057 80 90

0 1 2 3 4 5 6 7 8 9

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	M	A	M	J	J	A	S	O	N	D	
DAY		0	10	20	HOS2M_057									
		0	1	2	HOS2D_057								8	9
YEAR		01	02	03	04	05	06	07	08	09	10	11	12	

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

		0	10	20	HOS2N_057					70	80	90
		0	1	2	3	4	5	6	7	8	9	

NIGHTS

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

<p><b>What was the name and address of the physician who diagnosed the condition(s)?</b>  <b>IF AIDS RELATED, CODE IN QUESTIONS 1-3 AS APPROPRIATE</b></p> <p>Name of hospital/clinic or doctor</p> <p>Address</p> <p>City State Date</p>	1) Diagnosis or procedure	<input type="checkbox"/> V <input type="checkbox"/> E <input type="checkbox"/> P <b>TYHO21_057</b> <input type="checkbox"/> 0 <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500 <input type="checkbox"/> 600 <input type="checkbox"/> 700 <input type="checkbox"/> 800 <input type="checkbox"/> 900 <input type="checkbox"/> 0 <input type="checkbox"/> 10 <input type="checkbox"/> 20 <b>H2DX1_057</b> <input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 90 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
	2) Diagnosis or procedure	<input type="checkbox"/> V <input type="checkbox"/> E <input type="checkbox"/> P <b>TYHO22_057</b> <input type="checkbox"/> 0 <input type="checkbox"/> 100 <input type="checkbox"/> 200 <input type="checkbox"/> 300 <input type="checkbox"/> 400 <input type="checkbox"/> 500 <input type="checkbox"/> 600 <input type="checkbox"/> 700 <input type="checkbox"/> 800 <input type="checkbox"/> 900 <input type="checkbox"/> 0 <input type="checkbox"/> 10 <b>H2DX2_057</b> <input type="checkbox"/> 70 <input type="checkbox"/> 80 <input type="checkbox"/> 90 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9

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

No → **SKIP TO Q 7**  
 Yes **PHOS2\_057**

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

7. 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  
 Yes **DEPR\_057**  
 Don't know

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

		J	F	M	DEPRM_057			S	O	N	D
		01	02	03	DEPRY_057		09	10	11	12	

8. 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\_057**  
 Yes

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

This does not include any PAP smears performed as part of the MACS Anal Health Study.

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

- No → **GO TO Q 9.B** **APAPS\_057**
- Yes
- Don't Know → **GO TO Q 9.B**

(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
	01	02	03	04	05	06	07	08	09	10	11	12

**PAPSM\_057**  
**PAPSY\_057**

(3) Were the results abnormal?

- No → **GO TO Q 9.B** **ABRAP\_057**
- 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 Date

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\_057**

\* 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. **READ:** This includes any biopsies you have had as part of the MACS Anal Health Study.

- No
- Yes

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

**BIOPS\_057**

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

**BIOP\_057**    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.
1) Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP1_057</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/> <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"/>	Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX1_057</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>	Name of doctor _____ Name of hospital/center/clinic _____ _____ City _____ State _____ Date _____
2) Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP2_057</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/> <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"/>	Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX2_057</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>	Name of doctor _____ Name of hospital/center/clinic _____ _____ City _____ State _____ Date _____
3) Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="10"/> <b>BIOP3_057</b> <input type="text" value="70"/> <input type="text" value="80"/> <input type="text" value="90"/> <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"/>	Specify: _____ _____ <input type="text" value="0"/> <input type="text" value="1"/> <b>BIDX3_057</b> <input type="text" value="7"/> <input type="text" value="8"/> <input type="text" value="9"/>	Name of doctor _____ Name of hospital/center/clinic _____ _____ City _____ State _____ Date _____

GET MEDICAL RELEASE

3/8" spine perf

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\_057**
- B. Sinusitis, a sinus infection that requires antibiotics **SINUS\_057**
- C. Bronchitis **BRONC\_057**
- D. Erectile dysfunction (erectile problems) **ERDYS\_057**
- E. High blood pressure or hypertension **HBPHT\_057**
- F. High cholesterol, high triglycerides, high lipids or too much fat in your blood **HCHOL\_057**
- G. High blood sugar or diabetes **HBSUG\_057**
- H. Arthritis **ARTHR\_057**
  - IF YES: Was it: → Rheumatoid **RHEUM\_057**
  - (Read and answer each.) Osteoarthritis or degenerative **OSTAR\_057**
  - ← Other **OTHAR\_057**
  - Don't know **DKWAR\_057**

Specify:

Ask if in CVD2 study and if had medical follow-up. If yes, get medical release.

- \*I. Angina or chest pain caused by your heart **ANGIN\_057**
- \*J. Heart attack or myocardial infarction (MI) **HRTAT\_057**
- \*K. Congestive heart failure or CHF **HRTFA\_057**
- \*L. Stroke or Cerebrovascular accident (CVA) **STROK\_057**
- \*M. Mini-strokes or transient ischemic attacks (TIA) **TIA\_057**
- \*N. Too fast, too slow, or irregular heart beat **IRHB\_057**
- \*O. Any blood vessels (arteries) that were blocked or closed **BVES\_057**  
IF NO, SKIP TO Q Q
- \*P. An operation or other procedure, such as angioplasty, to open blocked blood vessels in your heart or other areas **OBVES\_057**
- \*Q. A blood clot in your legs **BCLG\_057**
- \*R. Kidney disease/Renal failure **KIDND\_057**
- S. An elevated liver enzyme **LIVDE\_057**
- T. Broken or fractured bone(s) **BBONE\_057**

C  
A  
-  
R  
E  
L  
E  
A  
S  
E  
I  
F  
B

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

---

Name of hospital/clinic or doctor

---

Address

---

City State Date

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

---

Name of hospital/clinic or doctor

---

Address

---

City State Date

**T.2 What was fractured?**

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

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	<b>BBSITE1_057</b>						8	9
0	1	2	3	4	5	6	7	8	9

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

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	<b>BBSITE2_057</b>						8	9
0	1	2	3	4	5	6	7	8	9

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

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	<b>BBSITE3_057</b>						8	9
0	1	2	3	4	5	6	7	8	9

**T.3 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 **BBHOW\_057**
- Don't know

**SERIAL #**

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

**a) Eyes**

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

NO YES

**VIDEY\_057**  
**EYDIA\_057**

SKIP  
TO  
b

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**ENDIA\_057**

SKIP  
TO  
c

Specify:

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

**c) Heart and Blood Vessels**

Ask if in CVD2 study and if had follow-up. If yes, get medical release.

**GET MEDICAL RELEASE**

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

NO YES

**VIDHT\_057**

SKIP  
TO  
d

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**LGDIA\_057**

SKIP  
TO  
e

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**SLDIA\_057**

SKIP  
TO  
f

IF LIVER DISEASE, GET MEDICAL RELEASE

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**BJDIA\_057**

SKIP  
TO  
g

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

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**GUDIA\_057**

SKIP  
TO  
h

Specify:

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
0	1	2	3	4	5	6	7	8	9
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\_057**  
**SKDIA\_057**

SKIP  
TO  
i

Specify:

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

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

NO YES

**VIDNS\_057**

SKIP  
TO  
j

Specify:

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



CC. Continued

NO YES

**j) Treatment of depression, anxiety or other mental health problems**  
**IF YES:** Was there a diagnosis?  
 What was the diagnosis?

NO YES  
**VIDPY\_057**  
**PYDIA\_057**

SKIP TO k

Specify:

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

**PYCON\_057**

NO YES

**k) Hormones or Endocrine system**  
**IF YES:** Was there a diagnosis?  
 What was the diagnosis?

NO YES  
**VIDHO\_057**  
**HODIA\_057**

SKIP TO l

Specify:

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

**HOCON\_057**

NO YES

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

NO YES  
**VIDO\_057**  
**ODIA\_057**

SKIP TO Q11.A

1.

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

**OCON1\_057**

2.

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

**OCON2\_057**

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

\_\_\_\_\_

Name of hospital/clinic or doctor

\_\_\_\_\_

Address

\_\_\_\_\_

City State Date

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

\_\_\_\_\_

Name of hospital/clinic or doctor

\_\_\_\_\_

Address

\_\_\_\_\_

City State Date

**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\_057**

2) Sores in genital region **HERPG\_057**

3) Sores in the anal or rectal areas **HERPA\_057**

4) Sores elsewhere on your body **HERPE\_057**

**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\_057**

**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\_057**

**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\_057**

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

**A.2) Was this a new infection or was it a continuation or relapse of a previous infection?** **SYPHN\_057**

- New infection
- Continued or relapse

**B) Any form of gonorrhea** **GONOR\_057**

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

**C) Urethral gonorrhea (clap or drip of the urinary passage)** **UGONA\_057**

**D) Oral gonorrhea (of the mouth or throat)** **OGONA\_057**

**E) Rectal gonorrhea (of the rectum)** **RGONA\_057**

**F) Non-specific or nongonococcal urethritis or chlamydia (that is, a discharge from the penis that's not caused by gonorrhea)** **URETC\_057**

**G.1) Genital warts (condylomata acuminata)** **WARTG\_057**

**IF "NO," SKIP TO (H)**

**G.2) Was this a new infection or was it a continuation or relapse of a previous infection?** **WRTGN\_057**

- New infection
- Continued or relapse

**H.1) Anal warts (condylomata acuminata)** **WARTS\_057**

**IF "NO," SKIP TO Q13.A**

**H.2) Was this a new infection or was it a continuation or relapse of a previous infection?** **WRTSN\_057**

- New infection
- Continued or relapse

3/8" spine perf

**SERIAL #**

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

PROBLEM OR SYMPTOM  FOR EACH "YES" IN a, ASK b, c, d, AND e.	a		b		c		d			e	
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES
1) Persistent dizziness for at least 3 consecutive days	<input type="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"/>
	DIZZI_057		DIZ2W_057		DIZNO_057		DZMED_057			DIZNC_057	
2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	FATIG_057		FAT2W_057		FATIN_057		FTMED_057			FATNC_057	
3) Persistent or recurring fever higher than 100° for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	FEVER_057		FEV2W_057		FEVRN_057		FVMED_057			FEVNC_057	
4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	HEADA_057		HED2W_057		HEADN_057		HDMED_057			HEANC_057	
5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	RASH_057		RAS2W_057		RASHN_057		RHMED_057			RSHNC_057	
6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	GLAND_057		GLN2W_057		GLANN_057		GLMED_057			GLANC_057	
7) Diarrhea for at least 3 consecutive days	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	DIARR_057		DIA2W_057		DIARN_057		DIMED_057			DIANC_057	
8) Drenching sweats at night on at least 3 occasions	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	SWEAT_057		SWT2W_057		SWETN_057		SWMED_057			SWENC_057	
9) Nausea, vomiting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	VOMIT_057		VOT2W_057		VOTNO_057		VTMED_057			VOTNC_057	
10) Abdominal pain, bloating, cramps	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	BLOAT_057		ABP2W_057		ABPNO_057		ABMED_057			ABPNC_057	
11) Ascites (fluid buildup in the stomach or abdomen)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	ASCIT_057		ASC2W_057		ASCNO_057		ASMED_057			ASCNC_057	
12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	JDICE_057		JDI2W_057		JDINO_057		JDMED_057			JDINC_057	
13) An unintentional weight loss of at least 10 pounds (unrelated to dieting)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	WTLOS_057				WTLSN_057		WTMED_057			WTLNC_057	
14) Muscle pain or weakness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	MPAIN_057		MPW2W_057		MPWNO_057		MPMED_057			MPWNC_057	

3/8" spine perf

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> .	a		b		c		d			e	
	NO	YES	NO	YES	NO	YES	NO	YES	DON'T KNOW	NO	YES
15) Joint pain	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	JOINT_057		JNT2W_057		JNTNO_057		JTMED_057			JNTNC_057	
16) Vivid nightmares or dreams	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	DREAM_057		NVD2W_057		NVDNO_057		DRMED_057			NVDNC_057	
17) Insomnia or problems sleeping	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
	INSOM_057		IPS2W_057		IPSNO_057		INMED_057			IPSNC_057	
18) Persistent dry mouth	<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"/>
	DRYMO_057		DRY2W_057		DRYNO_057		DMMED_057			DRYNC_057	

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 DON'T KNOW
	NO	YES			
1. Pain, aching, or burning in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	<input type="radio"/>
	FEETP_057 →		Left	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	PLMED_057
2. Pins and needles in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	<input type="radio"/>
	PINSF_057 →		Left	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	PIMED_057
3. Numbness (lack of feeling) in your feet or legs?	<input type="radio"/>	<input type="radio"/>	Right	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	<input type="radio"/>
	NUMBF_057 →		Left	<input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9 <input type="text"/> 10	NBMED_057

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\_057

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\_057
- 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\_057

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                     | NO                    | YES                   |
| b) After or during a bowel movement                               | <input type="radio"/> | <input type="radio"/> |
| c) Other times not associated with intercourse or bowel movements | <input type="radio"/> | <input type="radio"/> |
- ANBSX\_057  
ANBBM\_057  
ANBOT\_057

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

3/8" spine perf



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

- No → **SKIP TO Q 16** **ML2AD\_057**  
 Yes



(2) Please name those drugs that you have taken.

**FILL IN THE BUBBLE NEXT TO THE DRUG(S). FOR DRUGS NOT ON THE LIST, RECORD THE NAME UNDER "OTHER" AS STATED BY THE PARTICIPANT AND FILL IN THE CODE (REFER TO DRUG FORM 2 LIST).**

- |   |   |
|---|---|
| <input type="radio"/> atovaquone (Mepron, BW566C80) (190)               | <input type="radio"/> ganciclovir (Cytovene, DHPG, valcyte, valganciclovir) (125) |
| <input type="radio"/> azithromycin (Zithromax) (152)                    | <input type="radio"/> interleukin 2 (IL-2) (096)                                  |
| <input type="radio"/> Bactrim (Septra, TMP/SMX) (112)                   | <input type="radio"/> Marinol (dronabinol) (547)                                  |
| <input type="radio"/> ciprofloxacin (Cipro) (153)                       | <input type="radio"/> Megace (megestrol acetate) (123)                            |
| <input type="radio"/> clarithromycin (Biaxin) (184)                     | <input type="radio"/> NAC (N-acetyl cysteine) (188)                               |
| <input type="radio"/> co-enzyme Q (196)                                 | <input type="radio"/> Nandrolone (deca-durabolin) (232)                           |
| <input type="radio"/> colony stimulating factor (G-CSF, Neupogen) (157) | <input type="radio"/> Oxandrin (oxandrolone) (228)                                |
| <input type="radio"/> dapsone (113)                                     | <input type="radio"/> rifabutin (Mycobutin, Ansamycin) (093)                      |
| <input type="radio"/> DHEA (dihydroepiandrosteronedione) (161)          | <input type="radio"/> Serostim (human growth hormone) (245)                       |
| <input type="radio"/> erythropoietin (Epogen, Procrit, Aranesp) (117)   |   |
| <input type="radio"/> ethambutol (Myambutol) (137)                      |   |
| <input type="radio"/> fluconazole (Diflucan) (116)                      |   |
| <input type="radio"/> foscarnet (foscavir) (091)                        |   |

Other from Drug List 2 (Report Acyclovir in Q 16.)

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

**ML2A1\_057**  
**ML2A2\_057**

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

**ML2A3\_057**  
**ML2A4\_057**  
**ML2A5\_057**  
**ML2A6\_057**  
**ML2A7\_057**  
**ML2A8\_057**

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

**ML2A9\_057**  
**ML210\_057**  
**ML211\_057**  
**ML212\_057**

**RECORD ALL REPORTED TESTOSTERONE IN Q 16.1.a.**

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

You are being asked about your use of the following types of medications because of their potential effects on your overall health, including your long term risks for development of illnesses such as diabetes, heart disease, and osteoporosis, as well as their potential overall effects on the health of your muscles, liver, kidneys, and your sexual functioning. Similarly, the health effects of normal aging may be impacted by the use of these medications.

**Testosterone:**

16.1a Since your last visit, have you used testosterone in any of the following preparations, including *Androgel, Testim, Fortesta, Androderm (patch), Testosterone injection (Delatestryl)*?

- Yes **TSLV\_057**  
 No → **SKIP TO Q 16.2a**  
 Don't Know → **SKIP TO Q 16.2a**  
 (if don't know, center may call participant to verify)

If yes:

16.1b Was the testosterone prescribed by a health care provider?

- Yes  No **TSHC\_057**

16.1c What were the reasons for using testosterone? Was it because of [Read each item]

- Low testosterone level **TSRLL\_057**  
 Wasting or unintentional weight loss **TSRWL\_057**  
 To build muscle mass **TSRMM\_057**  
 Erectile Dysfunction **TSRED\_057**  
 Low sexual desire **TSRSD\_057**

16.1c (continued)

- Fatigue **TSRFT\_057**  
 Anemia (low red blood cells) **TSRAN\_057**  
 To feel stronger or more energetic **TSRSE\_057**  
 Improve athletic performance **TSRAP\_057**  
 Also taking Megace (megesterol) **TSRME\_057**  
 Other **TSROT\_057**

If yes: specify \_\_\_\_\_

16.1d How was it administered? Was it by [Read each item]

- Injection **TSAIN\_057**  
 If yes: Have you gotten an injection in the last 2 weeks? **TSAINW\_057**  
**TSAGL\_057**  
 Gel or patch **TSAGLH\_057**  
 If yes: Have you applied it in the last 24 hours? **TSASP\_057**  
**TSASPM\_057**  
 Under skin pellet (Testopel) \_\_\_\_\_  
 If yes: Have you had a pellet placed in the last 6 months? \_\_\_\_\_



16. Continued

**Anabolic steroids:**

16.2a Since your last visit, have you taken any anabolic steroids, such as *Anadrol-50*, *Winstrol*, *Oxandrin*?

- Yes
  - No → **SKIP TO Q 16.3a**
  - Don't know → **SKIP TO Q 16.3a**
  - Other anabolic steroid Specify: **ASLV\_057**
- (if don't know, center may call participant to verify)

If yes or other:

16.2b What were the reasons for taking this/these steroid(s)? [Read each item]

- Wasting or unintentional weight loss **ASRWL\_057**
- To build muscle mass **ASRMM\_057**
- To feel stronger or more energetic **ASRSE\_057**
- Improve athletic performance **ASRAP\_057**
- Other **ASROT\_057**

If yes: specify \_\_\_\_\_

16.2c Have you taken/used the anabolic steroids in the past 5 days?

- Yes
- No **AS5D\_057**

**Glucocorticoids (corticosteroids):**

16.3a Thinking about medications taken in your past, have you EVER taken any steroids by mouth called glucocorticoids or corticosteroids, such as *prednisone*, *dexamethasone (Decadron)*, *hydrocortisone*, *prednisolone (Prelone)*, *methylprednisolone (Medrol)*?

- Yes
  - No → **SKIP TO Q 16.3f**
  - Don't know → **SKIP TO Q 16.3f**
- (if don't know, center may call participant to verify)

If yes:

16.3b Approximately, how old were you when you last took any?

**GCAGE\_057**

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

16.3c Have you ever taken any of these steroid pills for a period of greater than 3 months?

- Yes
- No **GC3M\_057**

16.3d Now thinking about since your last visit only, how many days in total have you taken glucocorticoid or corticosteroid pills? (if none, fill in 0)

**GCLVD\_057**

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

"If NOT taken since last visit (days=0), skip to Q 16.3f"

16.3e What were the reasons for taking this/these steroid(s) since your last visit? (mark all that apply)

- Adrenal insufficiency **GCRAI\_057**
- Lung condition **GCRLC\_057**
- Joint condition **GCRJC\_057**
- Back condition **GCRBC\_057**
- Skin condition **GCRSC\_057**
- Other **GCROT\_057**

16.3f Since your last visit, have you had an injection of this/these steroid(s) into your skin or joints, back, muscle? **GCINJ\_057**

- Yes
- No → **IF Q 16.3d = 0 AND Q 16.3f = NO, THEN SKIP TO Q 16.4a**

16.3g Have you taken/used the glucocorticoid(s) or corticosteroid(s) by any means in the past 5 days?

- Yes
- No **GC5D\_057**

16.4a Since your last visit, have you taken any inhaled steroids?

(Note - to interviewer: If the participant reported an inhaled medication, but is not sure whether it was a steroid, read aloud the names of the drugs listed below.)

- Yes
- No **ISLV\_057**

If yes:

16.4b Which one(s):

- beclometh **ISBE\_057**
- QVAR **ISQV\_057**
- budesonid **ISBU\_057**
- Pulmicort **ISPU\_057**
- ciclesonid **ISCI\_057**
- Alvesco **ISAL\_057**
- flunisolide **ISFLN\_057**
- AeroBid **ISAB\_057**
- fluticasone **ISFLT\_057**
- Flovent **ISFLO\_057**
- mometasone **ISMO\_057**
- Asmanex Twisthaler **ISAT\_057**
- triamcinolone **ISTR\_057**
- Azmacort **ISAZ\_057**
- budesonide and formoterol **ISBF2\_057**
- Symbicort **ISSY\_057**
- fluticasone and salmeterol **ISFS2\_057**
- Advair **ISAD\_057**
- mometasone and formoterol **ISMF2\_057**
- Dulera **ISDU\_057**

16.4c Have you taken/used the inhaled steroid(s) in the past 5 days?

- Yes
- No **IS5D\_057**

16.5a Since your last visit, have you taken thyroid hormones, such as *Synthroid*, *Levoxyll*, *levothyroxine*, or *Cytome*?

- Yes
  - No → **SKIP TO Q 16.6a**
  - Don't know → **SKIP TO Q 16.6a**
  - Other thyroid hormone
- (if don't know, center may call participant to verify)

If yes, specify: \_\_\_\_\_

16.5b Have you taken/used thyroid hormone(s) in the past 5 days?

- Yes
- No **TH5D\_057**

16. Continued

ASK EACH ITEM	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) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug	ANTBV_057	Name:	ANTB5_057																																								
7) Tranquilizers or sleeping pills	TRNQV_057	Name:	TRNQ5_057																																								
8) Antidepressants or mood elevators	MOODV_057	Name:	MOOD5_057																																								
9) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex) IF YES, did you take it:  Everyday? <input type="radio"/> No <input type="radio"/> Yes CHACY_057 Only when you had active lesions or had an outbreak? <input type="radio"/> No <input type="radio"/> Yes EPACY_057	ACYCV_057	Name:	ACYC5_057																																								
10) Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction	VIAGR_057	Name:	VIAG5_057																																								
11) Aspirin taken three days or more on a weekly basis	ASPRN_057	Name:	ASPR7_057																																								
12) Medications to lower cholesterol, triglycerides, lipids or blood fat a. <table border="1" data-bbox="375 1094 756 1220"> <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> CHDG1_057	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	CHOL1_057 SKIP TO Q 16.13	Name:	CHL15_057
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																																		
b. <table border="1" data-bbox="375 1304 756 1430"> <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> CHDG2_057	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	CHOL2_057 SKIP TO Q 16.13	Name:	CHL25_057
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																																		
c. <table border="1" data-bbox="375 1514 756 1640"> <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> CHDG3_057	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	CHOL3_057 SKIP TO Q 16.13	Name:	CHL35_057
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																																		

3/8" spine perf





16. Continued

ASK EACH ITEM		a	b	c	
IF "NO" TO a GO TO ITEM 16a		How about (EACH)? Have you (taken/used) any since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	Have you taken/used any in the past 5 days (FOR ASPIRIN:in the last week)?	
		NO YES		NO YES	
15) Medications to treat hepatitis	a.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> 0 10 20 <b>HEPT1_057</b> 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	NO YES <b>HEPD1_057</b>  SKIP TO Q 16.16	Name:   Name:   NO YES <b>HEP15_057</b>
	b.	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> 0 10 20 <b>HEPT2_057</b> 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	NO YES <b>HEPD2_057</b>  SKIP TO Q 16.16	Name:   Name:   NO YES <b>HEP25_057</b>

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG. IF "NO" TO a GO TO Q17.A.			
a	b	c	d
Have you (taken/used) any other medications since your last visit [in (MONTH, YEAR)]?	When specified, what was the name of the (KIND OF DRUG) you took?	What did you take this drug for?	Have you taken/used any in the past 5 days?
16 ) Other  NO YES a. <b>ODRG1_057</b> SKIP TO Q 17.A	Name:  <input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 <input type="text"/> 0 100 <b>DRUG1_057</b> 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Used for:   	NO YES <b>ODG15_057</b>
NO YES b. <b>ODRG2_057</b> SKIP TO Q 17.A	Name:  <input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 <input type="text"/> 0 100 <b>DRUG2_057</b> 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Used for:   	NO YES <b>ODG25_057</b>
NO YES c. <b>ODRG3_057</b> SKIP TO Q 17.A	Name:  <input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 <input type="text"/> 0 100 <b>DRUG3_057</b> 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Used for:   	NO YES <b>ODG35_057</b>
NO YES d. <b>ODRG4_057</b> SKIP TO Q 17.A	Name:  <input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 <input type="text"/> 0 100 <b>DRUG4_057</b> 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Used for:   	NO YES <b>ODG45_057</b>
NO YES e. <b>ODRG5_057</b> SKIP TO Q 17.A	Name:  <input type="text"/> 0 1000 2000 3000 4000 5000 6000 7000 8000 9000 <input type="text"/> 0 100 <b>DRUG5_057</b> 700 800 900 <input type="text"/> 0 10 20 30 40 50 60 70 80 90 <input type="text"/> 0 1 2 3 4 5 6 7 8 9	Used for:   	NO YES <b>ODG55_057</b>

3/8" spine perf

16. Continued

ASK EACH ITEM UNTIL FIRST "NO" TO OTHER DRUG. IF "NO" 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>16) Other</p> <p>NO YES</p> <p>f. <b>ODRG6_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 <b>DRUG6_057</b> 700 800 900</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_057</b></p>
<p>NO YES</p> <p>g. <b>ODRG7_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 10 <b>DRUG7_057</b> 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>ODG75_057</b></p>
<p>NO YES</p> <p>h. <b>ODRG8_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 10 <b>DRUG8_057</b> 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>ODG85_057</b></p>
<p>NO YES</p> <p>i. <b>ODRG9_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 10 <b>DRUG9_057</b> 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>ODG95_057</b></p>
<p>NO YES</p> <p>j. <b>ODRG10_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 10 <b>DRUG10_057</b> 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>ODG105_057</b></p>
<p>NO YES</p> <p>k. <b>ODRG11_057</b></p> <p>SKIP TO Q 17.A</p>	<p>Name:</p> <p><input type="text"/></p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 100 200 300 400 500 600 700 800 900</p> <p><input type="text"/> 0 10 <b>DRUG11_057</b> 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>ODG115_057</b></p>

3/8" spine perf

SERIAL #

**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)?**

- No **ADAP\_057**
- 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\_057**
- Yes - did you have

	NO	YES
1) Coverage by an HMO		<b>HMOC_057</b>
2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)		<b>GPIC_057</b>
3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)		<b>IPIC_057</b>
4) Medicaid, Medi-Cal, or Medical Assistance		<b>MCAID_057</b>
5) Medicare (for people over 65 or permanently disabled)		<b>MCARE_057</b>
6) Health care benefits for The Armed Forces or Veteran's Administration, TRICARE, CHAMPUS or CHAMP-VA medical insurance for dependents of military personnel or survivors of disabled veterans.		<b>HCVET_057</b>
7) Ryan White		<b>RWHIT_057</b>
8) Other		<b>OTHER_057</b>
Specify:		

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

- No **INSDG\_057**
- 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\_057**
- Yes

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

- No **DINS\_057**
- Yes

3/8" spine perf

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 Have you used (EACH) since your last visit [in (MONTH, YEAR)]?	b How many times? (99 = 99 or more)
1) HMO	NO YES HMOOV_057	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
2) Doctor's office or specialty clinic (non-HMO) including Urgent Care	NO YES DOCOV_057	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
3) Any other clinic	NO YES CLOV_057	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
4) Emergency room	NO YES EROV_057	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9
5) Other outpatient service (Specify below)	NO YES OPOV_057	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

Specify:

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

SERVICE	a Have you seen one since your last visit [in (MONTH, YEAR)]?	b How many times? (99 = 99 or more)
1) Dental health care provider (such as dentist or dental hygienist)	DENTV_057 <input type="radio"/> NO GO TO Q 21.a <input type="radio"/> YES	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 30 40 50 60 70 80 90 0 1 2 3 4 5 6 7 8 9

21.a. We are also interested in oral hygiene, which may affect the transmission of infections. How often do you usually brush your teeth?

- Don't brush at all
- Less than once a day
- 1 time per day
- 2 times per day
- 3 times or more per day

BRUSH\_057

SERIAL #



27.

**Abbreviated interview**

No **ABINT\_057**

Yes

Date interview completed \_\_\_\_\_

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

**S4TEH\_057**  
**S4TEM\_057**  
**S4TEZ\_057**

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\_057**

28.

**CLINIC IDENTIFIERS**

BA Moore clinic

BA Whitman Walker

CH Howard Brown

CH Northwestern

CH CORE

Pitt Men's Study

PI Columbus

LA Wilshire

LA LAGLC

LA Harbor

**CLNID\_057**

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

**Anti-HIV Medications (PREP or PEP) Questions**  
 It has been reported that some people NOT infected with HIV take anti HIV medications to try to prevent getting HIV when having sex.

29. In the past 2 years, have you used anti-HIV medications to try to prevent YOURSELF from getting infected either before being exposed to HIV or following a possible exposure to HIV; this is sometimes called PREP (for pre-exposure prophylaxis) or PEP (for post-exposure prophylaxis)?

No → **SKIP TO Q30** **PROPEXP\_057**

Yes

Don't remember → **SKIP TO Q30**

HIV infected (Not applicable) → **SKIP TO Q30**

	1 <sup>st</sup> Medication	2 <sup>nd</sup> Medication	3 <sup>rd</sup> Medication
<b>29.a. Which anti-HIV medications did you take? Show list of medications and photos. Record all medications and ask questions below for each drug.</b>	<input type="radio"/> Truvada (253)	<input type="radio"/> Truvada (253)	<input type="radio"/> Truvada (253)
	<input type="radio"/> Emtriva (FTC) (239)	<input type="radio"/> Emtriva (FTC) (239)	<input type="radio"/> Emtriva (FTC) (239)
	<input type="radio"/> Viread (tenofovir) (234)	<input type="radio"/> Viread (tenofovir) (234)	<input type="radio"/> Viread (tenofovir) (234)
	<input type="radio"/> Atripla (262)	<input type="radio"/> Atripla (262)	<input type="radio"/> Atripla (262)
	<input type="radio"/> Epzicom (254)	<input type="radio"/> Epzicom (254)	<input type="radio"/> Epzicom (254)
	<input type="radio"/> Isentress (Raltegravir) (264)	<input type="radio"/> Isentress (Raltegravir) (264)	<input type="radio"/> Isentress (Raltegravir) (264)
	<input type="radio"/> Nevirapine (Viramune) (191)	<input type="radio"/> Nevirapine (Viramune) (191)	<input type="radio"/> Nevirapine (Viramune) (191)
	<input type="radio"/> Norvir (Ritonavir) (211)	<input type="radio"/> Norvir (Ritonavir) (211)	<input type="radio"/> Norvir (Ritonavir) (211)
	<input type="radio"/> Prezista (darunavir) (256)	<input type="radio"/> Prezista (darunavir) (256)	<input type="radio"/> Prezista (darunavir) (256)
	<input type="radio"/> Reyataz (atazanavir) (243)	<input type="radio"/> Reyataz (atazanavir) (243)	<input type="radio"/> Reyataz (atazanavir) (243)
	<input type="radio"/> Sustiva (efavirenz) (220)	<input type="radio"/> Sustiva (efavirenz) (220)	<input type="radio"/> Sustiva (efavirenz) (220)
	<input type="radio"/> Other prescribed (998)	<input type="radio"/> Other prescribed (998)	<input type="radio"/> Other prescribed (998)
	<input type="radio"/> Over-the-counter or herbal prep (539)	<input type="radio"/> Over-the-counter or herbal prep (539)	<input type="radio"/> Over-the-counter or herbal prep (539)

**PROP1MED\_057**

**PROP2MED\_057**

**PROP3MED\_057**

**SERIAL #**

3/8" spine perf

29. Continued

29.b. In the last 6 months, did you use this drug when you knew or suspected you would be having sex, or after sex?	1 <sup>st</sup> Medication			2 <sup>nd</sup> Medication			3 <sup>rd</sup> Medication		
	<input type="radio"/> No → <b>GO TO Q 29.d</b>	<b>PROP1L6M_057</b>		<input type="radio"/> No → <b>GO TO Q 29.d</b>	<b>PROP2L6M_057</b>		<input type="radio"/> No → <b>GO TO Q 29.d</b>	<b>PROP3L6M_057</b>	
29.c. If YES, when did you take (Name of Medication)	No	Yes	DK	No	Yes	DK	No	Yes	DK
1) Within 12 hours before having sex	<b>PROP1ASEX_057</b>			<b>PROP2ASEX_057</b>			<b>PROP3ASEX_057</b>		
2) More than 12 hours before having sex	<b>PROP1BSEX_057</b>			<b>PROP2BSEX_057</b>			<b>PROP3BSEX_057</b>		
3) Within 12 hours after having sex	<b>PROP1CSEX_057</b>			<b>PROP2CSEX_057</b>			<b>PROP3CSEX_057</b>		
4) More than 12 hours after having sex	<b>PROP1DSEX_057</b>			<b>PROP2DSEX_057</b>			<b>PROP3DSEX_057</b>		
29.d. How often did you typically use this drug in the last 6 months? <b>Choose one:</b>	<b>PROP1FRQ_057</b>			<b>PROP2FRQ_057</b>			<b>PROP3FRQ_057</b>		
1) Daily or almost daily	<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		
2) Once or twice per week	<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		
3) At least once per month, but less than weekly	<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		
4) Only once or twice in the last 6 months	<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		
5) Used in the last 2 years, but not last 6 months	<input type="radio"/>			<input type="radio"/>			<input type="radio"/>		
29.e. How did you obtain this medication?	No	Yes		No	Yes		No	Yes	
It was prescribed by my doctor	<b>PROP1OB1_057</b>			<b>PROP2OB1_057</b>			<b>PROP3OB1_057</b>		
As part of a clinical research study	<b>PROP1OB2_057</b>			<b>PROP2OB2_057</b>			<b>PROP3OB2_057</b>		
From a sexual partner	<b>PROP1OB3_057</b>			<b>PROP2OB3_057</b>			<b>PROP3OB3_057</b>		
From some other non-medical source	<b>PROP1OB4_057</b>			<b>PROP2OB4_057</b>			<b>PROP3OB4_057</b>		
	<b>Are there other medications?</b>			<b>Are there other medications?</b>					

30. At present, which of the following categories describes your annual individual gross income before taxes? [SHOW CARD TO PARTICIPANT OR READ ALOUD.] **INCOMNEW\_057**

- Less than \$10,000
- 10,000–19,999
- 20,000–29,999
- 30,000–39,999
- 40,000–49,999
- 50,000–59,999
- 60,000–99,999
- 100,000–149,999
- 150,000 or more
- Does not wish to answer

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

- No → **SKIP TO Q 32** **FNDIF\_057**
- Yes

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

- Less **FNDFL\_057**
- Same
- Greater

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** **JOBHI\_057**
- Yes

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

- |                                       | NO | YES              |
|---------------------------------------|----|------------------|
| 1) Became too sick to work            |    | <b>TSICK_057</b> |
| 2) Early retirement                   |    | <b>RETEY_057</b> |
| 3) Changed job as a personal decision |    | <b>JOBPE_057</b> |
| 4) Other                              |    | <b>JOBOT_057</b> |

Specify:

3/8" spine perf

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.1) Have you ever smoked cigarettes?

- No → **SKIP TO Q 33D** **ESMOK\_057**  
 Yes

A.2) Thinking about the entire time you have smoked cigarettes, what percentage of that time did you smoke menthol cigarettes?

- 100–75% of the time **SMOKM\_057**  
 Less than 75% but greater than 25% of the time  
 Less than 25% of the time

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

- No → **SKIP TO Q 33D** **SMOKN\_057**  
 Yes  
 Occasionally (less than one cigarette per day)  
→ **SKIP TO Q 33D**

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

- Less than 1/2 pack **PACKS\_057**  
 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

D. Since your last visit [in MONTH, YEAR], how many months have you lived in a household with at least one cigarette smoker other than yourself? Please think about multiple households in which you lived.

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

**SMOKHM\_057**

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\_057**

D. 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\_057**

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.

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\_057**

- Never → **STOP – SKIP TO Q 34D**  
 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\_057**

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

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**  
 Yes **SEXAV\_057**

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

- No → **SKIP TO Q 39**  
 Yes **SEXVF\_057**

**GO TO QUESTION 37 ON NEXT PAGE.**

SERIAL #



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

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

**NSEXF\_057**

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

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

**NSXAF\_057**

**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\_057**

- 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\_057**

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

- No
- Yes **MPFIV\_057**

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

- Negative
- Positive
- Don't Know **MPHIVE\_057**

The next questions are about different kinds of sexual activity men have with women.  
**IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 38.6**

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

KIND OF ACTIVITY	a Did you do this/engage in this activity with a woman since your last visit [in (MONTH, YEAR)]?	b How many women did you do that with since your last visit [in (MONTH, YEAR)]? (Give me the actual number) (IF NEEDED: What's your best estimate?)
1) You put your penis in her mouth (oral sex).	NO YES <b>OINF1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 <b>NOINF_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9
2) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (4).	NO YES <b>VINF1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 20 <b>NVINF_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9
<b>IF MULTIPLE PARTNERS:</b> 3) 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?  <b>IF ONE PARTNER:</b> Did you use a condom <u>every</u> time for vaginal sex, even if it broke, tore, or slipped?	NO YES <b>CVIF1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 <b>NCVIF_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9
4) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (6).	NO YES <b>AINF1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 <b>NAINF_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9
<b>IF MULTIPLE PARTNERS:</b> 5) With how many of those women did you use a condom <u>every</u> time for anal sex, even if it broke, tore, or slipped?  <b>IF ONE PARTNER:</b> Did you use a condom <u>every</u> time for anal sex, even if it broke, tore, or slipped?	NO YES <b>CAIF1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 <b>NCAIF_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9
6) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).	NO YES <b>DWKW1_057</b>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 100 200 300 400 500 600 700 800 900 <input type="text"/> <input type="text"/> <input checked="" type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 10 <b>NDWKW_057</b> 70 80 90 <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> 0 1 2 3 4 5 6 7 8 9

38 spine part

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

- No
- Yes



SKIP TO Q 41.10

SEXVM\_057



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

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

NSEXM\_057

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

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

NNSXM\_057

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\_057**

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

**Exchange partner: Someone you exchanged money or drugs with for sex.**

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\_057**

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

No       Yes      **MPMIV\_057**

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

Negative     Positive     Don't Know      **MPHIVM\_057**

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 41.9

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.	NO YES <b>ORIN1_057</b>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td><b>NOINM_057</b></td><td>70</td><td>80</td><td>90</td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	<b>NOINM_057</b>	70	80	90						0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	<b>NOINM_057</b>	70	80	90																													
	0	1	2	3	4	5	6	7	8	9																									
2) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (5).	NO YES <b>ANIN1_057</b>	<table border="1"> <tr><td></td><td>0</td><td>100</td><td>200</td><td>300</td><td>400</td><td>500</td><td>600</td><td>700</td><td>800</td><td>900</td></tr> <tr><td></td><td>0</td><td>10</td><td><b>NAINM_057</b></td><td>70</td><td>80</td><td>90</td><td></td><td></td><td></td><td></td></tr> <tr><td></td><td>0</td><td>1</td><td>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</td></tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	<b>NAINM_057</b>	70	80	90						0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	<b>NAINM_057</b>	70	80	90																													
	0	1	2	3	4	5	6	7	8	9																									

3/8" spine perf

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><b>IF MULTIPLE PARTNERS:</b></p> <p>3b.) 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 (Q3b &lt; Q2b) then read:</b>                      For those men with whom you did not use a condom,</p> <p>3b.1) Were any of these men HIV positive? →</p> <p>3b.2) Were any of these men HIV negative? →</p> <p><b>If 3b.1 or 3b.2 = Don't Know/Not Sure, skip to 3b.4.</b></p> <p>3b.3) Were you unsure of the HIV status of any of these men? →</p> <p>3b.4) 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>		<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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NC AIM_057</p> <p>DON'T KNOW/NOT SURE NO YES</p> <p>3b.1) HPAIM_057</p> <p>3b.2) HNAIM_057</p> <p>3b.3) HUAIM_057</p> <p>3b.4)</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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NAEJM_057</p>	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					
<p><b>IF ONE PARTNER:</b></p> <p>4a.) 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 4a = No:</b></p> <p>4a.1) What was the HIV status of your partner when you did not use a condom?</p> <p>4a.2) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</p>	<p>NO YES</p> <p>CAIN1_057 →</p> <p>DON'T KNOW/NOT SURE NEG. POS.</p> <p>HIVSTAT1_057</p> <p>NO YES</p> <p>AEJM1_057</p>	<p>SKIP TO Q 4a.2</p>																																																												
<p>5) He put his penis in your mouth. IF NONE, SKIP TO ITEM (6).</p>	<p>NO YES</p> <p>ORRC1_057</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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NORCM_057</p>	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9																														
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					
<p>6) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (9).</p>	<p>NO YES</p> <p>ANRC1_057</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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NARIM_057</p>	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9																														
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					
<p><b>IF MULTIPLE PARTNERS:</b></p> <p>7b.) Thinking of the times when a man put his penis in their 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 (Q7b &lt; Q6b) then read:</b>                      Of the men who did not use a condom,</p> <p>7b.1) Were any of these men HIV positive? →</p> <p>7b.2) Were any of these men HIV negative? →</p> <p><b>If 7b.1 or 7b.2 = Don't Know/Not Sure, skip to 7b.4.</b></p> <p>7b.3) Were you unsure of the HIV status of any of these men? →</p> <p>7b.4) 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>		<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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NCARM_057</p> <p>DON'T KNOW/NOT SURE NO YES</p> <p>7b.1) HPARM_057</p> <p>7b.2) HNARM_057</p> <p>7b.3) HUARM_057</p> <p>7b.4)</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>2</td><td>3</td><td>4</td><td>5</td><td>6</td><td>7</td><td>8</td><td>9</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>NAREM_057</p>	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9	0	100	200	300	400	500	600	700	800	900	0	10	2	3	4	5	6	7	8	9	0	1	2	3	4	5	6	7	8	9
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					
0	100	200	300	400	500	600	700	800	900																																																					
0	10	2	3	4	5	6	7	8	9																																																					
0	1	2	3	4	5	6	7	8	9																																																					

3/8" spine perf

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><b>IF ONE PARTNER:</b></p> <p>8a.) 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 8a = No:</p> <p>8a.1) What was the HIV status of your partner when he did not use a condom?</p> <p>8a.2) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</p>	<p>NO YES  <b>CANR1_057</b></p> <p>NEG. POS. DON'T KNOW/NOT SURE  <b>HIVSTAT2_057</b></p> <p>NO YES  <b>AREM1_057</b></p>	<p><b>SKIP TO Q 8a.2</b></p>																																	
<p>9) You engaged in deep wet kissing (where one of you put your tongue into the other's mouth).</p>	<p>NO YES  <b>DWKS1_057</b></p>	<table border="1"> <tr> <td></td> <td>0</td> <td>100</td> <td>200</td> <td>300</td> <td>400</td> <td>500</td> <td>600</td> <td>700</td> <td>800</td> <td>900</td> </tr> <tr> <td></td> <td>0</td> <td>10</td> <td><b>NDWKM_057</b></td> <td>70</td> <td>80</td> <td>90</td> <td></td> <td></td> <td></td> <td></td> </tr> <tr> <td></td> <td>0</td> <td>1</td> <td>2</td> <td>3</td> <td>4</td> <td>5</td> <td>6</td> <td>7</td> <td>8</td> <td>9</td> </tr> </table>		0	100	200	300	400	500	600	700	800	900		0	10	<b>NDWKM_057</b>	70	80	90						0	1	2	3	4	5	6	7	8	9
	0	100	200	300	400	500	600	700	800	900																									
	0	10	<b>NDWKM_057</b>	70	80	90																													
	0	1	2	3	4	5	6	7	8	9																									

41.10) Have you met any new partners with whom you had sexual intercourse since your last visit [in (MONTH, YEAR)]? Again, we define sexual intercourse as inserting your penis into your partner's mouth, vagina, or anus/butt, with or without ejaculation.

No → **SKIP TO Q 42**      **METPLV\_057**

Yes

41.11) Where did you meet this **LAST NEW** partner? Participant should select one. **METPLVHOW\_057**

- |  |   |
|--|---|
| <input type="radio"/> a) on the internet   | <input type="radio"/> f) in a park or other outdoor public place                |
| <input type="radio"/> b) at a circuit party  | <input type="radio"/> g) in a bathroom, bookstore, or other indoor public place |
| <input type="radio"/> c) through an advertisement in a newspaper or other newsletter | <input type="radio"/> h) at a place where drugs were used or exchanged          |
| <input type="radio"/> d) at a bar  | <input type="radio"/> i) group or sex party                                     |
| <input type="radio"/> e) at a bath house   | <input type="radio"/> j) other place not listed above                           |

41.12) Which of the following drugs and alcohol, if any, did you use with this **LAST NEW** male or female sexual partner during intercourse or sexual activity? (Please select all that apply to you.)

- |   |   |
|---|---|
| <input type="checkbox"/> a. No alcohol or drugs used <b>IF NONE, METPLVDRG0_057</b> | <input type="checkbox"/> h. Powder cocaine <b>METPLVDRG7_057</b>                          |
| <input type="checkbox"/> b. Alcohol <b>METPLVDRG1_057</b>                           | <input type="checkbox"/> i. Crack cocaine <b>METPLVDRG8_057</b>                           |
| <input type="checkbox"/> c. Marijuana <b>METPLVDRG2_057</b>                         | <input type="checkbox"/> j. Viagra, Levitra, and/or Cialis <b>METPLVDRG9_057</b>          |
| <input type="checkbox"/> d. Poppers <b>METPLVDRG3_057</b>                           | <input type="checkbox"/> k. Injectable Caverjet or TriMix <b>METPLVDRG10_057</b>          |
| <input type="checkbox"/> e. Crystal methamphetamine <b>METPLVDRG4_057</b>           | <input type="checkbox"/> l. Herbal supplements to promote erection <b>METPLVDRG11_057</b> |
| <input type="checkbox"/> f. GHB <b>METPLVDRG5_057</b>                               | <input type="checkbox"/> (Ginseng, Gingko Biloba, Yohimbe Bark Extract)                   |
| <input type="checkbox"/> g. Ecstasy <b>METPLVDRG6_057</b>                           | <input type="checkbox"/> m. Other drug not listed above <b>METPLVDRG12_057</b>            |

41.13) How often have you used condoms with this **LAST NEW** male or female sexual partner?

Always **METPLVCDM\_057**

Sometimes

Never

**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)
<b>Pot, Marijuana or Hash</b>  <b>What were the reasons for using pot? Select all that apply</b> <input type="radio"/> For medical reasons <input type="radio"/> For recreational reasons, not including sex <input type="radio"/> For sexual enhancement reasons <input type="radio"/> To increase ability to socialize <input type="radio"/> To fit in with a group	NO YES <b>HASHV_057</b> GO TO NEXT ROW  <b>HASHR1_057</b> <b>HASHR2_057</b>  <b>HASHR3_057</b> <b>HASHR4_057</b> <b>HASHR5_057</b>	<input type="radio"/>	<b>HASHF_057</b>	<input type="radio"/>						
<b>"Poppers" like nitrite inhalants (amyl, butyl or isopropyl nitrites)</b>	NO YES <b>POPPV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>POPPF_057</b>	<input type="radio"/>						
<b>Crack or cocaine that you smoke</b>	NO YES <b>CRACV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>CRACF_057</b>	<input type="radio"/>						
<b>Other forms of cocaine</b>	NO YES <b>OCOKV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>OCOKF_057</b>	<input type="radio"/>	<b>COCSNR_057</b>	<b>COCSWL_057</b>	<b>COCANU_057</b>	<b>COCINJ_057</b>		
<b>Speed, Meth or Ice</b>	NO YES <b>UPPRV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>UPPRF_057</b>	<input type="radio"/>	<b>SMISNR_057</b>	<b>SMISWL_057</b>	<b>SMIANU_057</b>	<b>SMISMK_057</b>	<b>SMIINJ_057</b>	
<b>Heroin</b>	NO YES <b>HEROV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>HEROF_057</b>	<input type="radio"/>	<b>HERSNR_057</b>	<b>HERSWL_057</b>	<b>HERANU_057</b>	<b>HERSMK_057</b>	<b>HERINJ_057</b>	
<b>Speedball (heroin and cocaine together)</b>	NO YES <b>SPEBV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>SPEBF_057</b>	<input type="radio"/>	<b>SPBSNR_057</b>	<b>SPBSWL_057</b>	<b>SPBANU_057</b>	<b>SPBSMK_057</b>	<b>SPBINJ_057</b>	
<b>Ecstasy, XTC, X or MDMA</b>	NO YES <b>MDAV_057</b> GO TO NEXT ROW	<input type="radio"/>	<b>MDAF_057</b>	<input type="radio"/>						
<b>Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction</b> <b>Definition:</b> Includes Viagra, Herbal Viagra, Levitra, Cialis, Testosterone patch, injection or topical creams, Yohimbine, Ephedrine or Guarana containing products, Tri-Mix, Penile suppositories, or any other compound, herbal preparation.	NO YES <b>SEXPD_057</b> GO TO NEXT PAGE	<input type="radio"/>	<b>SEXPO_057</b>	<input type="radio"/>						

3/8" spine perf

	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)
Other kinds of street/club drugs	NO YES <b>STMDV_057</b> GO TO Q 43.A									
Specify:	<b>STMD1_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST1DF_057</b>	<input type="radio"/>						
Specify:	<b>STMD2_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST2DF_057</b>	<input type="radio"/>						
Specify:	<b>STMD3_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST3DF_057</b>	<input type="radio"/>						
Specify:	<b>STMD4_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST4DF_057</b>	<input type="radio"/>						
Specify:	<b>STMD5_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST5DF_057</b>	<input type="radio"/>						
Specify:	<b>STMD6_057</b> 0 1 2 3 4 5 6 7 8 9	<input type="radio"/>	<b>ST6DF_057</b>	<input type="radio"/>						

IF NO INJECTING DRUG USE (Q 42.c injected=NO), SKIP TO Q 45

43.A. You mentioned that since your last visit you have injected recreational drugs. Do you currently inject drugs?

- No **RCDNO\_057**
- Yes

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

- No → **SKIP TO Q 45** **PNEP\_057**
- Yes

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

- Less than half the time
- Half the time **HONEP\_057**
- Most of the time
- Always

45. 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
- Yes **DRGTP\_057**

**Interviewer Instructions:**

**Thank the participant.**

**Record the time ended on page 22.**

PLEASE DO NOT WRITE IN THIS AREA



**SERIAL #**