INTERVIEW INTRODUCTION

First, I'm going to ask you about your health history. I'll be reading you a series of questions about diseases, symptoms, and medicines you may have had in the past. At the beginning of each section, I'll read a question to you; if anything I ask you is unclear, please stop me and I will try to make the question clearer.

I understand that some of these questions may be difficult for you to answer and dates may be hard to remember exactly. Please take as much time as you need so that I may collect information which is as accurate as possible.

Finally, I need to re-emphasize that all your answers are confidential, and the responses you provide will in no way affect your clinical care.
1. Since we last saw you, have you been diagnosed with an AIDS-defining illness or AIDS?

- [ ] No  [ ] Yes  [ ] SKIP TO Q 2

Let's start with a list of medical conditions. You may not have heard of some of them because they are rare, but if you've had any of them, you'll know it. [Since we last saw you in (MONTH)] Has a doctor or medical provider, such as a nurse or physician's assistant, told you that you had any of the following? How about (EACH)?

<table>
<thead>
<tr>
<th>Condition</th>
<th>YESNO</th>
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</thead>
<tbody>
<tr>
<td>A. Kaposi's Sarcoma or KS</td>
<td>YESNO</td>
</tr>
<tr>
<td>B. Pneumocystis carinii pneumonia (PCP)</td>
<td>YESNO</td>
</tr>
<tr>
<td>C. Other pneumonia or lung infections other than bronchitis</td>
<td>YESNO</td>
</tr>
<tr>
<td>D. Toxoplasmosis or Toxo Infection</td>
<td>YESNO</td>
</tr>
<tr>
<td>E. Cytomegalovirus (CMV) in your eyes, lungs, colon, or other location.</td>
<td>YESNO</td>
</tr>
<tr>
<td>F. MAI, MAC or Mycobacterial Infection</td>
<td>YESNO</td>
</tr>
<tr>
<td>G. Lymphoma, specify</td>
<td>YESNO</td>
</tr>
<tr>
<td>H. Meningitis related to HIV or Cryptococcal Meningitis</td>
<td>YESNO</td>
</tr>
<tr>
<td>I. Cryptococcal Infection without Meningitis</td>
<td>YESNO</td>
</tr>
<tr>
<td>J. Candida or thrush, a yeast infection of the esophagus (the tube between your mouth and stomach)</td>
<td>YESNO</td>
</tr>
</tbody>
</table>

In what month and year was it first diagnosed? IF "NO" TO B, GO TO NEXT ROW. In what month and year was it first diagnosed?
1. Continued

<table>
<thead>
<tr>
<th></th>
<th>In what month and year was it first diagnosed?</th>
</tr>
</thead>
<tbody>
<tr>
<td>M. Herpes Simplex Infection of the lungs or esophagus (the tube between your mouth and stomach)</td>
<td>[ ] January [ ] February [ ] March [ ] April [ ] May [ ] June [ ] July [ ] August [ ] September [ ] October [ ] November [ ] December</td>
</tr>
<tr>
<td>P. Dementia or Encephalopathy or a memory problem or confusion caused by HIV</td>
<td>[ ] January [ ] February [ ] March [ ] April [ ] May [ ] June [ ] July [ ] August [ ] September [ ] October [ ] November [ ] December</td>
</tr>
</tbody>
</table>

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

Name of hospital/clinic or doctor

Address

City State

2. The next few questions are about Tuberculosis, or TB for short. To see if a person has tuberculosis a doctor or nurse will give a skin test—sometimes called a PPD test. If the skin test shows the person has been exposed or infected with tuberculosis, more tests are done to see if they are sick from the tuberculosis. A person might get an X-ray or be asked to cough into a machine. If they are sick, we say they have “tuberculosis disease”. Sometimes this is called “active” or “infectious tuberculosis”. Usually, if a person has tuberculosis disease, people who live or work with the person will be tested for tuberculosis too.

A. Have you ever had a skin test for TB, sometimes called a PPD?  

B. IF YES: When was your last test?  

C. Was it positive?
3. A. [Since we last saw you in (MONTH)] Have you had an active TB infection?  
   
   B. Was the TB in your lungs?
   C. Was the TB in any other part of your body (other than your lungs)?

4. DROPPED

5. Has a doctor or other medical provider ever told you that you had any cancer (other than Kaposi’s Sarcoma, primary brain lymphoma, or non-Hodgkin’s lymphoma)?

   IF "NO," GO TO Q 6
   IF YES

   a. What kind of cancer? In what month and year was it first diagnosed?

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

   1)
   Name of hospital/clinic or doctor
   Address
   City State

   2)
   Name of hospital/clinic or doctor
   Address
   City State

6. Have you ever had an organ transplant?

7. Have you had any radiation treatment in the last 20 years, other than x-rays by the dentist or to diagnose problems in your lungs or bones?
8.A. At anytime during the last 6 months, have you been admitted to the hospital for any reason? This would include staying overnight or being admitted for a procedure that was done in one day. Please include all medical and psychiatric hospitalizations. This doesn’t include being treated in the emergency room and later released.

- [ ] No  [ ] Yes  **SKIP TO Q 9**

How many separate times did you stay overnight as a patient in a hospital in the last 6 months?

- [ ] 0  [ ] 1  [ ] 2  [ ] 3  [ ] 4  [ ] 5  [ ] 6  [ ] 7  [ ] 8  [ ] 9

**GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL**

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

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

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   | DAY | 0| 1| 2| 3| 4| 5| 6| 7| 8| 9| 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|
   |     | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|

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   | NIGHTS | 0| 1| 2| 3| 4| 5| 6| 7| 8| 9| 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30|
   |        | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|

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

   - [ ] 0  [ ] 1  [ ] 2  [ ] 3  [ ] 4  [ ] 5  [ ] 6  [ ] 7  [ ] 8  [ ] 9

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

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

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

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

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

   d. Did you have any other prior hospitalizations in the last 6 months?

   - [ ] No  [ ] Yes  **SKIP TO Q 8.C**

   IF MORE THAN 2 HOSPITALIZATIONS, MARK HERE AND USE CONTINUATION SHEET.

8.B. (2) c. For what condition or problem were you hospitalized and the name/address of the hospital? RECORD FULLY IN R’s OWN WORDS.

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

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

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</table>

   | DAY | 0| 1| 2| 3| 4| 5| 6| 7| 8| 9| 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|
   |     | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|

   |      | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 | 13 | 14 | 15 | 16 | 17 | 18 | 19 | 20 | 21 | 22 |

   | NIGHTS | 0| 1| 2| 3| 4| 5| 6| 7| 8| 9| 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30|
   |        | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10| 11| 12| 13| 14| 15| 16| 17| 18| 19| 20| 21| 22| 23| 24| 25| 26| 27| 28| 29| 30| 31|

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

   - [ ] 0  [ ] 1  [ ] 2  [ ] 3  [ ] 4  [ ] 5  [ ] 6  [ ] 7  [ ] 8  [ ] 9

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

   d. Did you have any other prior hospitalizations in the last 6 months?

   - [ ] No  [ ] Yes  **SKIP TO Q 8.C**

   IF MORE THAN 2 HOSPITALIZATIONS, MARK HERE AND USE CONTINUATION SHEET.

8.C. Have you ever been hospitalized, prescribed drugs, or consulted a mental health professional for treatment of depression?

   - [ ] No  [ ] Yes  **SKIP TO Q 10**

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

   - [ ] Not applicable for those participants who do not have living blood-related family members or do not know them because they are adopted.  **SKIP TO Q 10**

Have any members of your immediate family ever been hospitalized, prescribed drugs, or treated for depression?

   - [ ] No  [ ] Yes  [ ] Don’t Know  **SKIP TO Q 10**

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

1. High blood pressure or hypertension
2. Pancreatitis
3. Diabetes or high blood sugar
4. Chest pain related to heart disease
5. Heart attack before age 60
6. Stroke
7. Congestive Heart Failure
8. Mini-strokes or transient ischemic attacks (TIA)
9. High blood cholesterol or high lipids
10. Hip fracture or broken hip before age 60
11. Cancer

   - [ ] No  [ ] Yes  [ ] Don’t Know  **SKIP TO Q 10**
9. B. Continued

<table>
<thead>
<tr>
<th>IF YES: Was it:</th>
<th>NO</th>
<th>YES</th>
<th>DON'T KNOW</th>
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<tbody>
<tr>
<td>a. Skin Cancer</td>
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<tr>
<td>b. Colon Cancer</td>
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<td>c. Prostate Cancer</td>
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<tr>
<td>d. Other Cancer</td>
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Now we would like to talk about your specific conditions.

10. A. Have you had any biopsies of the skin or other tissues and organs in the last two years, other than from the anus or rectum? By biopsy, we mean removal of any tissue or gland to study under the microscope. We will ask you about anal and rectal biopsies later on.

- [ ] No
- [ ] Yes

REVIEW RESPONSE TO Q 5, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 11

B. How many times have you had a biopsy in the last 2 years?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

C. For each biopsy, please tell me:

1. Where in your body?

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<tr>
<th>Where was the biopsy performed?</th>
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<td>Specifying: Name of doctor</td>
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<td>Specifying: Name of hospital/center/clinic</td>
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<td>Specifying: City</td>
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<td>Specifying: State</td>
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<td>Specifying: DATE</td>
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</table>

11. A. Have you ever received a transfusion of blood or blood parts (platelets or plasma)?

- [ ] No
- [ ] Yes

B. How many times have you had a transfusion?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10

C. When was the last time?

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12. Have you ever had a flu vaccine?

- [ ] No
- [ ] Yes

IF YES: How old were you when you received your last one?

[ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ] 10 [ ] 11 [ ] 12 [ ] 13 [ ] 14 [ ] 15 [ ] 16 [ ] 17 [ ] 18 [ ] 19 [ ] 20 [ ] 21 [ ] 22 [ ] 23 [ ] 24 [ ] 25 [ ] 26 [ ] 27 [ ] 28 [ ] 29 [ ] 30 [ ] 31 [ ] 32 [ ] 33 [ ] 34 [ ] 35 [ ] 36 [ ] 37 [ ] 38 [ ] 39 [ ] 40 [ ] 41 [ ] 42 [ ] 43 [ ] 44 [ ] 45 [ ] 46 [ ] 47 [ ] 48 [ ] 49 [ ] 50 [ ] 51 [ ] 52 [ ] 53 [ ] 54 [ ] 55 [ ] 56 [ ] 57 [ ] 58 [ ] 59 [ ] 60 [ ] 61 [ ] 62 [ ] 63 [ ] 64 [ ] 65 [ ] 66 [ ] 67 [ ] 68 [ ] 69 [ ] 70 [ ] 71 [ ] 72 [ ] 73 [ ] 74 [ ] 75 [ ] 76 [ ] 77 [ ] 78 [ ] 79 [ ] 80 [ ] 81 [ ] 82 [ ] 83 [ ] 84 [ ] 85 [ ] 86 [ ] 87 [ ] 88 [ ] 89 [ ] 90 [ ] 91 [ ] 92 [ ] 93 [ ] 94 [ ] 95 [ ] 96 [ ] 97 [ ] 98 [ ] 99 [ ] 100 [ ]

13. Have you ever received an injection of Pneumococcal vaccine/Pneumovax?

- [ ] No
- [ ] Yes

Page 6
14. Has a doctor or other medical provider ever told you that you had (EACH)?

A. Shingles (or Herpes Zoster)
   **IF YES:** Which month and year did this episode of shingles (zoster) begin?

<table>
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<tr>
<th>Month</th>
<th>Year</th>
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B. Thrush (yeast in your mouth)
   **IF YES:** Which month and year did this episode of thrush begin?

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<tr>
<th>Month</th>
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C. Infectious Mononucleosis
D. Sickle Cell Anemia
E. Sinusitis (a sinus infection that requires antibiotics)
F. Bronchitis
G. Pancreatitis
H. High Blood Pressure or Hypertension
I. Injury to head with loss of consciousness
J. Angina or chest pain caused by your heart
K. Heart attack or myocardial infarction (MI)
L. Congestive Heart Failure or CHF
M. Stroke or cerebrovascular accident (CVA)
N. Seizure or convulsions
O. Osteoporosis (bone thinning)
P. Kidney Disease/Renal failure
Q. Arthritis
   **IF YES:** Was it: Rheumatoid
   **IF YES:** Was it: Osteoarthritis or degenerative
   **IF YES:** Was it: Other
   Specify:
   Don’t know what type

R. Avascular necrosis, osteonecrosis, or weakening or degeneration of your bones, especially hips or knees, not due to arthritis
S. Hepatitis or blood test that was positive for hepatitis?
   [This includes going to the doctor for chronic hepatitis.]
   **IF YES:** Was it: Hepatitis A or Infectious Hepatitis
   **IF YES:** Was it: Hepatitis B or Serum Hepatitis
   **IF YES:** Was it: Hepatitis C
   **IF YES:** Was it: Other
   Specify:
   Don’t know what type

T. Liver Disease
   **IF YES:** Was it: Cirrhosis
   **IF YES:** Was it: Fibrosis
   **IF YES:** Was it: Inflammation
   **IF YES:** Was it: Elevated liver function test enzyme
   **IF YES:** Was it: Other
   Specify:
   Don’t know what type

U. Have you ever received an injection of Hepatitis A vaccine?
V. Have you ever received an injection of Hepatitis B vaccine?
15. Have you ever had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system?  

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<th>NO</th>
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**IF YES:** Was there a diagnosis for your condition?

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**IF YES:** What was the diagnosis?

Specify:

16. In the last 2 years, have you seen a doctor or other medical provider for any (other) conditions or problems in the following areas?  

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<th>NO</th>
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**a) Affecting the whole body**  
*IF YES:* What was the diagnosis?

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**b) Eyes**  
*IF YES:* What was the diagnosis?

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**c) Ears, Nose, Throat, Mouth**  
*IF YES:* What was the diagnosis?

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**d) Heart**  
*IF YES:* What was the diagnosis?

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**e) Lungs**  
*IF YES:* What was the diagnosis?

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**f) Stomach and Intestines**  
*IF YES:* What was the diagnosis?

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**g) Bones, Joints or Muscles**  
*IF YES:* What was the diagnosis?

Specify:

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**h) Genital and Urinary**  
*IF YES:* What was the diagnosis?

Specify:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**i) Skin**  
*IF YES:* What was the diagnosis?

Specify:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**j) Nervous system**  
*IF YES:* What was the diagnosis?

Specify:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

Specify:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**l) Hormones**  
*IF YES:* What was the diagnosis?

Specify:
17. A. Have you ever had any of the following forms of herpes, not including shingles or herpes zoster?

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Facial herpes, cold sores, or fever blisters</td>
<td></td>
</tr>
<tr>
<td>2) Sores in genital region</td>
<td></td>
</tr>
<tr>
<td>3) Sores in the anal or rectal areas</td>
<td></td>
</tr>
<tr>
<td>4) Sores elsewhere on your body</td>
<td></td>
</tr>
</tbody>
</table>

IF "NO" TO ALL FOUR, SKIP TO Q 18

17. B. Was the first attack of herpes in the past 6 months?

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

17. C. Has there been a period during the past 6 months when your (herpes) sores seemed to come more often, get worse or last longer than usual?

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

18. Have you ever had any of the following diseases or conditions? How about (EACH)?

<table>
<thead>
<tr>
<th>DISEASE OR CONDITION</th>
<th>EVER HAD DISEASE</th>
<th>LAST 6 MONTHS?</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Syphilis</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>B) Any form of gonorrhea</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>C) Urethral gonorrhea (clap or drip of the urinary passage)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>D) Oral gonorrhea (of the mouth or throat)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>E) Rectal gonorrhea (of the rectum)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that’s not caused by gonorrhea)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>G) Genital warts or anal warts (condylomata acuminata)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>H) Chlamydia</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
19.A. Have you had any of the following problems or symptoms during the last 6 months?

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>1. How about (EACH)? Did you have that at any time during the last 6 months?</th>
<th>2. Did that last for two weeks or longer?</th>
<th>3. And do you have that now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Persistent fatigue (feeling tired all the time) for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>2. A new skin condition, rash, or infection that lasted for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>3. Diarrhea for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>4. Persistent or recurring fever higher than 100° for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>5. Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>6. Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>7. Drenching sweats at night on at least 3 occasions</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>8. Candida or white patches in your mouth or throat</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>9. Joint pain</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>10. Ascites (fluid buildup in the stomach or abdomen)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>11. Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>12. An unusual bruise or bump or skin discoloration that lasted at least two weeks</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>13. An unintentional weight loss of at least 10 pounds (unrelated to dieting)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>14. Anemia, low RBC, low hemoglobin</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>15. Unusual bleeding or bleeding that is difficult to stop</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
<tr>
<td>16. Persistent dizziness for at least 3 consecutive days</td>
<td>NO YES</td>
<td>NO YES</td>
<td>NO YES</td>
</tr>
</tbody>
</table>
### 19.A. Continued

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>How about (EACH)? Did you have that at any time during the last 6 months?</th>
<th>Did that last for two weeks or longer?</th>
<th>And do you have that now?</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) Nausea, vomiting</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>18) Abdominal pain, bloating, cramps</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>19) Muscle pain or weakness</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>20) Kidney stones</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>21) Painful urination</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>22) Fat maldistribution or abnormal changes in body fat</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>23) Vivid nightmares or dreams</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>24) Insomnia or problems sleeping</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>25) Anal bleeding</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>26) Persistent dry mouth</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>

#### 19.B. In the last 6 months have you experienced:

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>If NO, go to next question. If YES, indicate severity.</th>
</tr>
</thead>
</table>
| 1. Pain, aching, or burning in your feet or legs? | Severity
(0= None, 1= Mild, 10= Severe) |
| 2. Pins and needles in your feet or legs? | | |
| 3. Numbness (lack of feeling) in your feet or legs? | | |
20. A. Has a doctor or other medical provider tested your blood to see if you have HIV that is resistant to certain drugs? I am referring to the types of HIV drug resistant tests that are called genotyping and phenotyping.

- [ ] No
- [ ] Yes

**SKIP TO Q 21**

20. B. Has your treatment (drugs) been changed as a result of that test?

- [ ] No
- [ ] Yes
- [ ] Don't know

**SKIP TO Q 21**

21. Have you ever taken any HIV-related medications or treatments? (That is, medications or treatments to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS.)

- [ ] No
- [ ] Yes

**SKIP TO Q 21.B (1)**

21. A. IF NO: Why are you not taking HIV-related medications?

READ EACH, MARK ALL THAT APPLY

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

Specify:

**SKIP TO Q 22**

21. B. (1) Have you taken any medication or drug on this list [SHOW LIST 1 AND MEDICATION PHOTO CARDS]?

Please identify those medications that you have taken as I read/show you each one. How about (EACH)?

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>Ever taken</th>
<th>Year started</th>
<th>Taken in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>3-TC (Epivir, Lamivudine) (204)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>Abacavir (Ziagen) (218)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>Atripla (efavirenz + emtricitabine + tenofovir) (262)</td>
<td></td>
<td>01 02 03 04 05 06 07</td>
<td>08 09 10</td>
</tr>
<tr>
<td>Fosamprenavir (Lexiva) (249)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>Atazanavir (BMS-232632, Reyataz) (243)</td>
<td></td>
<td>01 02 03 04 05 06 07</td>
<td>08 09 10</td>
</tr>
<tr>
<td>Combigir (AZT &amp; 3-TC) (227)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>d4T (Zerit, Stavudine) (159)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>Darunavir (Prezista) (256)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>ddI (dideoxyinosine, Didanosine, Videx) (147)</td>
<td></td>
<td>01 02 03 04 05 06 07</td>
<td>08 09 10</td>
</tr>
<tr>
<td>Epzicom (abacavir + lamivudine) (254)</td>
<td></td>
<td>01 02 03 04 05 06 07</td>
<td>08 09 10</td>
</tr>
<tr>
<td>Efavirenz (Sustiva) (220)</td>
<td></td>
<td>01 02 03 04</td>
<td>05 06 07 08 09 10</td>
</tr>
<tr>
<td>Etravirine (Intelicence, TMC-125) (255)</td>
<td></td>
<td>01 02 03 04 05 06 07</td>
<td>08 09 10</td>
</tr>
</tbody>
</table>
21.B. (1) Continued

<table>
<thead>
<tr>
<th>MEDICATION</th>
<th>Ever taken</th>
<th>Year started</th>
<th>Taken in last 6 months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lopinavir/ritonavir (Kaletra, LPV) (217)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Raltegravir (Isentress, Merck Integrase Inhibitor, MK 0158) (264)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Nevirapine (Viramune) (191)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Ritonavir (Norvir) (211)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Saquinavir (Invirase, Fortovase) (210)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Tenofovir (Viread) (234)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Trizivir (abacavir + zidovudine + lamivudine) (240)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Truvada (tenofovir + emtricitabine) (253)</td>
<td>NO</td>
<td>01 02 03 04 05 06 07 08 09 10</td>
<td>NO YES</td>
</tr>
<tr>
<td>Other anti-viral from Drug List 1</td>
<td>NO</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify:
- 0: 01 02 03 04 05 06 07 08 09 10
- 1: 01 02 03 04 05 06 07 08 09 10

IF "YES" TO ANY DRUGS TAKEN IN THE LAST 6 MONTHS, SKIP TO Q 21.B. (3).

(2) IF NO USE IN LAST 6 MONTHS:

Why are you not taking HIV-related medications?

READ EACH, MARK ALL THAT APPLY

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

- Other reason

Specify:

- 0: 01 02 03 04 05 06 07 08 09
- 1: 01 02 03 04 05 06 07 08 09

(3) In the past 6 months, did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?

- No
- Yes [SKIP TO Q 21.C]

IF YES: How many times did this occur?

Specify:

- 0: 01 02 03 04 05 06 07 08 09
- 1: 01 02 03 04 05 06 07 08 09

Did your physician prescribe or agree to any of these?

- No
- Yes

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

Specify:

- 0: 01 02 03 04 05 06 07 08 09
- 1: 01 02 03 04 05 06 07 08 09
21.C. (1) In the past 6 months, 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 [ ]
- Yes [ ]

SKIP TO Q 21.D

(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.)

- atovaquone (Mepron, BW566C80) (190)
- azithromycin (Zithromax) (152)
- Bactrim (Septra, TMP/SMX) (112)
- ciprofloxacin (Cipro) (153)
- clarithromycin (Biaxin) (184)
- co-enzyme Q (196)
- colony stimulating factor (G-CSF, Neupogen) (157)
- dapsone (113)
- DHEA (dihydroepiandrosterone) (161)
- erythropoietin (Epogen, Procrit, Aranesp) (117)
- ethambutol (Myambutol) (137)
- fluconazole (Diffucan) (116)
- foscarinet (foscavir) (091)
- ganciclovir (Cytovene, DHGP, valcyclovir, valganciclovir) (125)
- interleukin 2 (IL-2) (096)
- Marinol (dronabinol) (547)
- Megace (megestrol acetate) (123)
- NAC (N-acetyl cysteine) (188)
- Nandrolone (deca-durabolin) (232)
- Oxandrin (oxandrolone) (228)
- rifabutin (Mycobutin, Ansamycin) (093)
- Serostim (human growth hormone) (245)
- testosterone (Androgel, Androderm, Delatestryl, Striant, Testoderm, Virilon) (236)
- Other from Drug List 2 (Report Acyclovir in Q 22.)

D. (1) In the past 6 months, have you taken any medication, drug or other therapy that was not listed to suppress or prevent getting sick because of HIV or treat the sickness related to HIV or AIDS?

- No [ ]
- Yes [ ]

SKIP TO Q 22

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

1.

2.

3.

4.

5.

6.

7.

Other from Drug List 2 (Report Acyclovir in Q 22.)
### Question 22

Now, I have some questions about drugs and medications that you may have taken for other health reasons. These include either prescribed drugs or other things you took on your own during the last 6 months.

#### Table

<table>
<thead>
<tr>
<th>Item</th>
<th>Medication Type</th>
<th>Question</th>
<th>YES/NO</th>
<th>Name</th>
<th>Used for</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Steroids</td>
<td>How about EACH? Have you taken/used any in the last 6 months?</td>
<td>NO/YES</td>
<td>Name</td>
<td>Used for</td>
</tr>
<tr>
<td>2</td>
<td>Thyroid hormone</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Other hormones</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Antibiotics</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Medication</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Medication</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Tranquilizers</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Antidepressants</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Lithium</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Acyclovir</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Viagra</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Cholesterol</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>Medications for diabetes</td>
<td></td>
<td></td>
<td>Name</td>
<td></td>
</tr>
</tbody>
</table>

#### Instructions

- **Ask each item until first “NO” to other drug (item 15a).**
- **If “NO” go to next item.**
- **When specified:**
  - What was the name of the kind of drug you took and what did you take this drug for?

#### Drug Categories

- Steroids that you took by mouth or were injected
- Thyroid hormone or medication
- Other hormones such as anabolic steroids
- Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug
- Medication taken by mouth for fungal infection
- Medication taken by mouth for worms or parasites
- Tranquilizers or sleeping pills
- Antidepressants or mood elevators
- Lithium
- Acyclovir, famciclovir or valacyclovir for herpes (zovir, famvir, valtrex)
- Viagra, Cialis, Levitra or other drugs that were prescribed by a medical provider to treat erectile dysfunction
- Cholesterol, triglycerides or lipid lowering medications
- Medications used for diabetes

#### Example

- **Item 1:**
  - Steroids that you took by mouth or were injected
  - **Question:** How about EACH? Have you taken/used any in the last 6 months?
  - **Options:** NO, YES
  - **Columns:** Name, Used for

- **Item 12:**
  - Cholesterol, triglycerides or lipid lowering medications
  - a. **SPECIFY in column b**
  - b. **SPECIFY in column b**

- **Item 13:**
  - Medications used for diabetes
  - a. **SPECIFY in column b**
  - b. **SPECIFY in column b**
### 14) Hepatitis medications

<table>
<thead>
<tr>
<th>a. (SPECIFY in column b)</th>
<th>b. (SPECIFY in column b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Used for:</td>
<td></td>
</tr>
</tbody>
</table>

**How about (EACH)?** Have you taken/used any in the last 6 months?

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
</table>

- **(WHEN SPECIFIED)** What was the name of the (KIND OF DRUG) you took and what did you take this drug for?

**a.** Other (SPECIFY in column b)

- **b.** Other (SPECIFY in column b)

### 15) Hypertension medications

<table>
<thead>
<tr>
<th>a. (SPECIFY in column b)</th>
<th>b. (SPECIFY in column b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name:</td>
<td></td>
</tr>
<tr>
<td>Used for:</td>
<td></td>
</tr>
</tbody>
</table>

**Ask each item until first "NO" to other drug (item 15a)**

**IF "NO" TO a GO TO NEXT ITEM**

<table>
<thead>
<tr>
<th>0 1 02 03 04 05 06 07 08 09 0</th>
<th>1 02 03 04 05 06 07 08 09 0</th>
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<tbody>
<tr>
<td>5M</td>
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</table>

**Skip to Q 22.15**

### 16) Other (SPECIFY in column b)

<table>
<thead>
<tr>
<th>a. Other (SPECIFY in column b)</th>
<th>b. Other (SPECIFY in column b)</th>
<th>c. Other (SPECIFY in column b)</th>
<th>d. Other (SPECIFY in column b)</th>
<th>e. Other (SPECIFY in column b)</th>
<th>f. Other (SPECIFY in column b)</th>
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</table>
23. A. Have you ever been given a vaccine against HIV in a trial?

☐ No .SKIP TO Q 24.  ☐ Yes

B. Do you know the name of the trial?

☐ No  ☐ Yes  Specify

C. Where did you go for this trial?

Name of hospital or clinic:

Address:

City  State

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

24. A. Do you currently have [ASK EACH ITEM AND RECORD ANSWER]

1) Coverage by an HMO ● ○

2) Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO) ● ○

3) Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO) ● ○

4) Medicaid, Medi-Cal, or Medical Assistance ● ○

5) Medicare (for people over 65 or permanently disabled) ● ○

6) Health care benefits for The Armed Forces or Veteran’s Administration ● ○

7) CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans ● ○

8) Other, such as ADAP or Ryan White ● ○

Specify:


24. B. Do you have insurance coverage that pays for all or some of your medications?

☐ No  ☐ Yes

IF NO TO Q 24.A (1)–(8) AND Q 24.B, THEN SKIP TO Q 28

25. A. In the past 6 months, have you changed or lost your medical coverage?

☐ No  ☐ Yes

B. If YES, was that change your choice?  ☐ No  ☐ Yes

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

1) Lost or quit job ● ○

2) Changed job (employer or employment status) ● ○

3) Employer changed or dropped coverage ● ○

4) Pre-existing medical condition limited choices ● ○

5) To be able to choose doctors or providers ● ○

6) More or better coverage of needed or desired services ● ○

7) Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed ● ○

8) Financial reasons (cost of premiums, co-payments or deductibles) ● ○

9) Eligible for Medicare ● ○

D. IF “YES” TO MORE THAN ONE RESPONSE IN Q 25.C, [READ ALL CHOICES AND SELECT ONLY ONE]

☐ Lost or quit job

☐ Changed job (employer or employment status)

☐ Employer changed or dropped coverage

☐ Pre-existing medical condition limited choices

☐ To be able to choose doctors or providers

☐ More or better coverage of needed or desired services

☐ Eligibility for Medicaid, Medi-Cal, or Medical Assistance changed

☐ Financial reasons (cost of premiums, co-payments or deductibles)

☐ Eligible for Medicare
26. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)

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

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

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

28. Do you currently have any type of dental insurance coverage?

- No
- Yes

29. Where do you usually go for medical care, even if you haven't received medical care in the past 6 months? [READ ALL CHOICES AND SELECT ONLY ONE]

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

Specify:

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

30. In the past 6 months, 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.]

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Have you used (EACH) in the past 6 months?</th>
<th>How many times? (99 = 99 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) HMO</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>![Box with numbers]</td>
<td>![Box with numbers]</td>
</tr>
<tr>
<td>2) Doctor's office (non-HMO) including Urgent Care</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>![Box with numbers]</td>
<td>![Box with numbers]</td>
</tr>
<tr>
<td>3) Any clinic</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>![Box with numbers]</td>
<td>![Box with numbers]</td>
</tr>
<tr>
<td>4) Emergency room</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>![Box with numbers]</td>
<td>![Box with numbers]</td>
</tr>
<tr>
<td>5) Other outpatient</td>
<td>NO</td>
<td></td>
</tr>
<tr>
<td></td>
<td>![Box with numbers]</td>
<td>![Box with numbers]</td>
</tr>
</tbody>
</table>

Specify:
31. In the past 6 months, have you used ANY of the following providers or services?

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Have you used (EACH) in the past 6 months?</th>
<th>How many times? (99 = 99 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Dental health care provider (such as dentist or dental hygienist)</td>
<td>NO: GO TO NEXT ROW</td>
<td>0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99</td>
</tr>
<tr>
<td></td>
<td>YES</td>
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</tbody>
</table>

32. DROPPED

33. A. Was there a time in the past 6 months when you did not seek medical care, or dental care, or did not obtain prescription medications that you thought you needed?

- No: SKIP TO Q 34.A
- Yes: 

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

1) Medical care

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

2) Dental care

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

3) Prescription medications

- No: GO TO Q 34.A
- Yes: Why did you not obtain prescription medications? [READ EACH AND MARK ALL THAT APPLY]
  - Financial reasons
  - Other non-financial reasons
  Specify: 

34. DROPPED
We would like to ask you some additional questions about medical conditions.

35. A. Has a doctor or other medical practitioner ever told you that you had...
   1) high cholesterol, high triglycerides, high lipids or too much fat in your blood?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   2) high blood sugar or diabetes?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   3) prostate problems (not cancer)?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   4) erectile dysfunction (erectile problems)?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   5) mini-strokes or transient ischemic attacks (TIA)?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   6) too fast, too slow, or irregular heart beat?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   7) any blood vessels (arteries) that were blocked or closed? [IF NO, SKIP TO 9]
      NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   8) an operation to open blocked blood vessels in your heart or other areas?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   9) a blood clot in your legs?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS
   10) a blood clot in your lungs?  NO, NEVER
      YES, BUT NOT IN LAST 6 MONTHS
      YES, WITHIN LAST 6 MONTHS

35. B. (1) Have you EVER undergone an anal pap smear?
   ○ No
   ○ Yes

   (2) In what month and year did you have the pap smear performed?  IF >2, ASK ABOUT MOST RECENT:
   [Month and Year]

   (3) Were the results abnormal?
   ○ No
   ○ Yes
     GET MEDICAL RELEASE

35. C. (1) Have you EVER undergone an anal biopsy?
   (By a biopsy, we mean removal of any tissue or gland to study under the microscope.)
   ○ No  GO TO Q 35.D. (1)
   ○ Yes

   (2) How many times have you had an anal biopsy with abnormal results?
     TIMES

   (3) In what month and year were you first diagnosed with abnormal results?
   [Month and Year]
   [IF MORE THAN ONE ABNORMAL BIOPSY, ASK Q 35.C (4).]
   [IF NOT, GO TO Q 35.D (1)].

35. D. (1) Are you circumcised?
   ○ No
   ○ Yes
   ○ Don't Know
   ○ Refused

   INTERVIEWER INSTRUCTIONS: For those who don't know, show pictures and ask participant to choose if he was circumcised according to the pictures.

   (2) If yes, what year were you circumcised?
   [Year]

   INTERVIEWER INSTRUCTIONS: Code 9999 if participant cannot remember when he was circumcised.

   (3) Were you circumcised before you were sexually active?
   ○ No
   ○ Yes
   ○ Don't Know
35.E.1 Were you diagnosed with any broken or fractured bone(s) on or after the age of 30?

- No
- Yes
- Not applicable (younger than 30)

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

Incident 1

35.E.1a What was fractured?

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

35.E.1b How old were you when this happened?

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

35.E.1c Did that fracture occur... (Select one option)

- Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- Because of a harder fall (example, falling down steps)
- From a car accident or other severe external force
- Don’t know

Incident 2

35.E.2a What was fractured?

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

35.E.2b How old were you when this happened?

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

35.E.2c Did that fracture occur... (Select one option)

- Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- Because of a harder fall (example, falling down steps)
- From a car accident or other severe external force
- Don’t know
### Incident 3

**35.E.3a** What was fractured?

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

<table>
<thead>
<tr>
<th>0</th>
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</table>

**35.E.3b** How old were you when this happened?

<table>
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<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
<th>50</th>
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</table>

**35.E.3c** Did that fracture occur... (Select one option)

- [ ] Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- [ ] As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- [ ] Because of a harder fall (example, falling down steps)
- [ ] From a car accident or other severe external force
- [ ] Don’t know

### Incident 4

**35.E.4a** What was fractured?

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

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<td>7</td>
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<td>9</td>
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**35.E.4b** How old were you when this happened?

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<th>30</th>
<th>40</th>
<th>50</th>
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<td>7</td>
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<td>9</td>
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</table>

**35.E.4c** Did that fracture occur... (Select one option)

- [ ] Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- [ ] As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- [ ] Because of a harder fall (example, falling down steps)
- [ ] From a car accident or other severe external force
- [ ] Don’t know

### Incident 5

**35.E.5a** What was fractured?

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

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<tr>
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</table>

**35.E.5b** How old were you when this happened?

<table>
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<th>0</th>
<th>10</th>
<th>20</th>
<th>30</th>
<th>40</th>
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<td>9</td>
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</table>

**35.E.5c** Did that fracture occur... (Select one option)

- [ ] Without any trauma or fall (i.e., without any external force: examples, rib fracture when coughing; spine fracture from lifting a heavy box)
- [ ] As a result of a fall from standing height or less (includes falls due to slipping or tripping)
- [ ] Because of a harder fall (example, falling down steps)
- [ ] From a car accident or other severe external force
- [ ] Don’t know
- [ ] More than 5 diagnosed fracture incidents

---

**See Appendix 9 in guidelines for list of fracture site codes.**
36. At present, which of the following categories describes your annual income?
   - Less than $10,000
   - $10,000–19,999
   - $20,000–29,999
   - $30,000–39,999
   - $40,000–49,999
   - $50,000–59,999
   - $60,000 or more
   - Does not wish to answer

37. Are you experiencing major financial difficulty meeting your basic expenses?
   - No
   - Yes

38. Has your employment status ever changed for any reason related to HIV disease?
   - No SKIP TO Q 39
   - Yes
   
   **IF YES: ASK:** What were the reasons?
   (READ EACH ITEM)
   
   NO YES
   1) Became too sick to work
   2) HIV status became known to employer
   3) HIV status became known to coworkers
   4) Early retirement
   5) Changed job as a personal decision
   6) To receive better health insurance benefits
   7) To receive better disability benefits
   8) Other

39. Continued

C. Do you smoke cigarettes now?
   (As of one month ago?)
   - No  SKIP TO (D)
   - Yes  SKIP TO (E)
   - Occasionally (less than one cigarette per day)  SKIP TO (F)

D. How long ago did you stop?
   - (1) 20
   - (2) 30
   - (3) 40
   - (4) 50
   - (5) 60
   - (6) 70
   - (7) 80
   - (8) 90
   - Months ago
   - Years ago

   NOW SKIP TO (F)

E. How many packs do you usually smoke per day?
   - Less than 1/2 pack
   - At least 1/2 pack but less than one per day
   - At least 1 but less than 2 packs
   - 2 or more packs per day

F. Thinking about the period of time when you smoked the most, how many (packs of) cigarettes did you smoke per day?
   - Never smoked regularly (never as much as 1 cigarette per day)
   - Less than 1/2 pack a day
   - At least 1/2 pack but less than one pack per day
   - At least 1 pack per day but less than 2
   - 2 or more packs per day

40. The next questions are about alcoholic beverages—that is, wine, beer or liquor you’ve drunk.

A. Did you drink any alcoholic beverages in the past year?
   - No  SKIP TO Q 41
   - Yes

B. How often did you have a drink containing alcohol (a glass of beer, wine, a mixed drink, any kind of alcoholic beverage)?
   - At least once a day
   - Nearly every day
   - About once a month
   - 3 to 4 times a week
   - 6–11 times a year
   - Once or twice a week
   - 1–5 times a year

C. On days when you drank any alcoholic beverages, how many drinks did you USUALLY have altogether? (By a drink we mean a can or glass of beer, a 4-ounce glass of wine, a 1 1/2-ounce shot of liquor, or a mixed drink with that amount of liquor.)
   - 1 or 2 drinks
   - 3 or 4 drinks
   - 5 or 6 drinks
   - 7 or more drinks

---

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

39. A. Have you ever smoked cigarettes?
   - No  SKIP TO Q 40
   - Yes

B. How old were you when you began smoking (cigarettes)?
   - 0
   - 1–15
   - 16–25
   - 26–35
   - 36–45
   - 46–55
   - 56–65
   - 66–75
   - 76–85
   - 86–95
I would like to ask you some questions about your sexual activity. I realize that this is a very personal subject. Your answers will be completely confidential.

**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.

41. Have you had any sexual activity with another person in the last 2 years?
- [ ] No  SKIP TO Q 50
- [ ] Yes

42. Have you had any sexual activity with a woman in the last 2 years?
- [ ] No  SKIP TO Q 46
- [ ] Yes

43. Have you had any sexual activity with a woman in the last 6 months?
- [ ] No  SKIP TO Q 46
- [ ] Yes

44. Now let’s talk about how many different women you have had sexual activity with in the last 6 months.
   A. How many different women (if any) have you had sexual intercourse with in the last 6 months? Here we define sexual intercourse as inserting your penis into your partner’s mouth, vagina, or anus/butt, with or without ejaculation.
   B. With how many other women have you had sexual activity that did not include intercourse in the last 6 months?

The next questions are about different kinds of sexual activity men have with women. If no intercourse with women, skip to Q 45.10

45. IF ONLY ONE PARTNER: USE COLUMN a.
   IF MULTIPLE PARTNERS: USE COLUMN b.
   KIND OF ACTIVITY
   1) You put your penis in her mouth (oral sex).
      IF NONE, SKIP ITEM (4).
   
   Did you do this/engage in this activity with a woman in the last 6 months?
   - [ ] No  - [ ] Yes

   How many women did you do that with (in the last 6 months)? (Give me the actual number) (IF NEEDED: What’s your best estimate?)

   IF MULTIPLE PARTNERS:
   2) With how many of those women did you use a condom every time for oral sex, even if it broke, tore, or slipped?
   IF ONE PARTNER:
   Did you use a condom every time you had oral sex even if it broke, tore, or slipped?
### 45. Continued

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

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a woman in the last 6 months?</th>
<th>How many women did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
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<tr>
<td>Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>4) You put your penis in her vagina (vaginal sex).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With how many of those women did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>5) With how many of those women did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With how many women did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>7) You put your penis in her anus/butt (anal sex).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>8) With how many of those women did you use a condom every time for anal sex, even if it broke, tore, or slipped?</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>With how many women did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>
45. Continued

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

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a woman in the last 6 months?</th>
<th>How many women did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (“rimming”).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

46. Have you had any sort of sexual activity with a man in the last 2 years?
   - No  SKIP TO Q 50
   - Yes

47. Have you had any sort of sexual activity with a man in the last 6 months?
   - No  SKIP TO Q 50
   - Yes

48. Now let’s talk about how many different men you have had sexual activity with in the last 6 months.
   A. How many different men (if any) have you had sexual intercourse with in the last 6 months? Here we define sexual intercourse as follows: you put your penis in your partner’s mouth or rectum—or your partner put his penis in your mouth or rectum, with or without ejaculation.
   
   B. With how many other men have you had sexual activity that did not include intercourse in the last 6 months?
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 49.13

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

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a man in the last 6 months?</th>
<th>How many men did you do that with [in the last 6 months]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (5).</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF ONE PARTNER: Thinking of the times you put your penis in his mouth, did you use a condom every time, even if it broke, tore, or slipped?</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>3) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)?</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF ONE PARTNER: Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>5) Thinking of the times you put your penis in their anus/butt, with how many men did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF ONE PARTNER: Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped?</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>6) With how many men did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</td>
<td>NO YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>IF ONE PARTNER: Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>
49. Continued

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>7) He put his penis in your mouth.</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>If none, skip to item (10).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8) Thinking of the times when a man put his penis in your mouth, with how many</td>
<td></td>
<td></td>
</tr>
<tr>
<td>men was a condom used <em>every</em> time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If one partner:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking of the times when he put his penis in your mouth, was a condom used</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><em>every</em> time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9) With how many men did ejaculate/cum go into your mouth when they did not use</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If one partner:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did ejaculate/cum go into your mouth when he did not use a condom (or when a</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) He put his penis in your anus/butt.</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>If none, skip to item (13).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) Thinking of the times when a man put his penis in your anus/butt, with how</td>
<td></td>
<td></td>
</tr>
<tr>
<td>many men was a condom used <em>every</em> time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If one partner:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thinking of the times he put his penis in your anus/butt, was a condom used</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td><em>every</em> time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12) With how many men did ejaculate/cum go into your anus/butt when they did not</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If one partner:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did ejaculate/cum go into your anus/butt when he did not use a condom (or when</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If multiple partners:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13) You used your tongue to touch or lick his anus/butt (“rimming”).</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

*Note: If needed, what's your best estimate?
The next few questions are asked to summarize your past sexual practices with both female and male partners.

50. When was the last time you had sexual intercourse with a woman?
   - Never
   - Within the last month
   - Within the last year (but not the last month)
   - 1–5 years ago
   - 6–10 years ago
   - More than 10 years ago

51. With how many different women have you had sexual intercourse in the past 2 years?

52. With how many different women have you had sexual intercourse in your whole life?

53. When was the last time you had sexual intercourse with a man?
   - Never
   - Within the last month
   - Within the last year (but not the last month)
   - 1–5 years ago
   - 6–10 years ago
   - More than 10 years ago

54. With how many different men have you had sexual intercourse in the past 2 years?

55. With how many different men have you had sexual intercourse in your whole life?

56. In summary, which of the following statements best describes your sexual activity during the last 2 years?
   - Had sexual activity only with women
   - Had sexual activity mostly with women, but some men
   - Had sexual activity about equally with women and men
   - Had sexual activity mostly with men, but some women
   - Had sexual activity only with men
57. 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 during the last two years?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>Have you (EACH) taken/used any in the last 2 years?</th>
<th>Have you taken/used (DRUG) in the last 6 months?</th>
<th>How often did you (use/take) (DRUG) during the last 6 months?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pot, Marijuana or Hash</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>&quot;Poppers&quot; like nitrite inhalants (amy, butyl or isopropyl nitrites)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Crack or cocaine that you smoke</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Other forms of cocaine</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Speed, Meth or Ice</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Heroin</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Speedball (heroin and cocaine together)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Ecstasy, XTC, X or MDMA</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Sexual performance enhancing drugs other than those prescribed by a medical provider for a diagnosed erectile dysfunction (Show list of performance enhancing drugs to prompt and assist with recall.)</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
<tr>
<td>Other kinds of street/club drugs</td>
<td>NO YES</td>
<td>NO YES</td>
<td>DAILY WEEKLY MONTHLY LESS OFTEN</td>
</tr>
</tbody>
</table>

Specify: 0 1 2 3 4 5 6 7 8 9
58. A. Have you ever injected recreational drugs (skin popped, shot up with a needle)?
   - No
   - Yes
   **SKIP TO Q 64**

   B. Were any of these times that you injected recreational drugs in a shooting gallery?
   - No
   - Yes

   C. Do you currently inject drugs?
   - No
   - Yes

   D. Thinking about the period when you injected the most, how many times did you inject [DRUG] per month?
   - Speedball (cocaine and heroin together)
     - 0
     - 1
     - 2
     - 3
     - 4
     - 5
     - 6
     - 7
     - 8
     - 9
     - 10
     - 20
     - 30
     - 40
     - 50
     - 60
     - 70
     - 80
     - 90
   - Cocaine by itself
     - 0
     - 1
     - 2
     - 3
     - 4
     - 5
     - 6
     - 7
     - 8
     - 9
   - Heroin by itself
     - 0
     - 1
     - 2
     - 3
     - 4
     - 5
     - 6
     - 7
     - 8
     - 9
   - Speed by itself
     - 0
     - 1
     - 2
     - 3
     - 4
     - 5
     - 6
     - 7
     - 8
     - 9

59. In the last 6 months, have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?
   - No
   - Yes
   **SKIP TO Q 61**

60. A. In the last 6 months, how many times have you used needles or works that were first used by someone else and then passed to you?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - 20
   - 30
   - 40
   - 50
   - 60
   - 70
   - 80
   - 90
   - 100

   B. With how many different people?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - 20
   - 30
   - 40
   - 50
   - 60
   - 70
   - 80
   - 90
   - 100

61. A. In the last 6 months, have you shared water to rinse your needles with anyone?
   - No
   - Yes
   **SKIP TO Q 62**

   B. How many times?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - 20
   - 30
   - 40
   - 50
   - 60
   - 70
   - 80
   - 90
   - 100

   C. With how many different people?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9
   - 10
   - 20
   - 30
   - 40
   - 50
   - 60
   - 70
   - 80
   - 90
   - 100

62. In the last 6 months, how often did you clean your works with bleach?
   - Never
   - Less than half the time
   - About half the time
   - Most of the time
   - Always

63. A. Have you participated in a needle exchange program?
   - No
   - Yes
   **SKIP TO Q 64**

   B. Of the times you obtained needles, how often did you get them from a needle exchange?
   - Less than half the time
   - Half the time
   - Most of the time
   - Always

   C. Do you have another source of clean needles?
   - No
   - Yes

64. 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
65.A. Is there anything more that I haven’t asked that you think we should know?

☐ No, nothing more  ☐ Yes

THANK PARTICIPANT AND SKIP TO Q 66

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


66. Date interview completed

67. Interviewer’s signature

INTERVIEWER’S NUMBER

CLINIC IDENTIFIERS

☐ BA Moore clinic
☐ BA Whitman Walker
☐ CH Howard Brown
☐ CH Northwestern
☐ CH CORE
☐ PI
☐ LA Wilshire
☐ LA LAGLC
☐ LA Harbor