1. Let's start with a list of medical conditions. Since your last visit [in (MONTH, YEAR)], were you diagnosed with any of the following? How about (EACH)?

<table>
<thead>
<tr>
<th>IF &quot;NO&quot; TO 3, GO TO NEXT ROW</th>
<th>YES</th>
<th>IN WHAT MONTH AND YEAR (SINCE YOUR LAST VISIT), WAS IT [FIRST] DIAGNOSED?</th>
<th>HOW MANY TIMES WERE YOU DIAGNOSED WITH THIS SINCE YOUR LAST VISIT? FOR 9 OR MORE TIMES CODE &quot;9&quot;</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Kaposi's sarcoma or KS</td>
<td>NO</td>
<td>YES</td>
<td>IF &quot;NO&quot; TO 3, GO TO NEXT ROW</td>
</tr>
<tr>
<td>B. Pneumocystis carinii</td>
<td>NO</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>C. Other pneumonia, specify</td>
<td>NO</td>
<td>YES</td>
<td>If more than 1 time, in what month and year was the most recent episode? Specify:</td>
</tr>
<tr>
<td>D. Toxoplasmosis or Toxo</td>
<td>NO</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>E. Cytomegalovirus infection</td>
<td>NO</td>
<td>YES</td>
<td></td>
</tr>
<tr>
<td>F. Mycobacterial infection</td>
<td>NO</td>
<td>YES</td>
<td></td>
</tr>
</tbody>
</table>

Please do not write in this area.
1. Continued

<table>
<thead>
<tr>
<th>Condition</th>
<th>Yes/No</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Lymphoma, specify</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary brain lymphoma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-Hodgkin’s</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td></td>
</tr>
<tr>
<td>H. Meningitis related to HIV or cryptococcal meningitis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>I. Candida or thrush, a yeast infection of the esophagus, not just your mouth</td>
<td></td>
<td></td>
</tr>
<tr>
<td>J. Cryptosporidiosis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>K. Wasting Syndrome or severe weight loss</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Name of hospital/clinic or doctor</th>
<th>Address</th>
<th>City</th>
<th>State</th>
</tr>
</thead>
</table>

2. [Since your last visit in (MONTH)] In addition to these diagnoses, has a doctor or medical practitioner told you that you have had any other AIDS conditions? Go to Q 50.B to record the name and address of the physician who diagnosed the condition(s).

<table>
<thead>
<tr>
<th>Date of Diagnosis</th>
<th>Month/Year</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3. [Since your last visit in (MONTH)] Has a doctor or medical practitioner told you that you had some form of cancer (excluding Kaposi’s sarcoma, primary brain lymphoma and non-Hodgkin’s lymphoma)?

   ☐ No  ☑ Yes

   IF “NO,” GO TO Q 4

IF YES: What kind of cancer did they say it was?

<table>
<thead>
<tr>
<th>Type</th>
<th>Site</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

In what month and year was it first diagnosed since your last visit?

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

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

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

4.A. [Since your last visit in (MONTH)] did you have a skin test for TB, sometimes called a PPD?

   ☑ No  ☐ YES

   SKIP TO Q 5

   B. IF YES: When was your last test?

<table>
<thead>
<tr>
<th>Month</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

   C. Was it positive?

   ☐ No  ☑ YES

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

   ☐ No  ☑ YES

   SKIP TO Q 6

   B. Was the TB in your lungs?

   C. Was the TB in any other part of your body (other than your lungs)?
6.A. [Since your visit in (MONTH)] Have you been hospitalized overnight?

- No
- Yes

How many separate times did you stay overnight as a patient in a hospital [since your visit in (MONTH)]?

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

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?

<table>
<thead>
<tr>
<th>MO</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YEAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

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

<table>
<thead>
<tr>
<th>MO</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
<th>11</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td>DAY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>YEAR</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

- 0
- 1
- 2
- 3
- 4
- 5
- 6
- 7
- 8
- 9
- 10

6.B. 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

d. Did you have another prior hospitalization [since your last visit in (MONTH)]?

- No
- Yes

IF MORE THAN 2 HOSPITALIZATIONS [SINCE VISIT IN (MONTH)], MARK HERE AND USE CONTINUATION SHEET.

7. Since your last visit, have you been hospitalized, prescribed medication, or consulted a mental health professional for treatment of depression?

- No
- Yes

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

Have any members of your immediate blood-related family ever been hospitalized, prescribed medication or consulted a mental health professional for treatment of depression?

- No
- Yes

Don’t know
8.B. Have any members of your immediate family ever suffered from (EACH)?

<table>
<thead>
<tr>
<th></th>
<th>NO</th>
<th>YES</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. High Cholesterol/Lipids</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. High Blood Sugar/Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. High Blood Pressure</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Stroke</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Chest Pain</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Heart Attack Before 60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Broken Hip Before 60</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Pancreatitis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Cancer</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF YES: Was it:
- a. Skin cancer
- b. Colon cancer
- c. Prostate cancer
- d. Other cancer

9.A. [Since your visit in (MONTH)] Have you had a biopsy? (By a biopsy, we mean removal of any tissue or gland to study under the microscope.)

- No
- Yes

REVIEW RESPONSE TO Q 3, IF DIAGNOSED WITH CANCER USE PROMPT AND RE-ASK QUESTION, OTHERWISE SKIP TO Q 10

B. How many times have you had a biopsy [since your last visit in (MONTH)]?

TIMES

C. For each biopsy, please tell me:

<table>
<thead>
<tr>
<th>Where in your body?</th>
<th>What did they say the diagnosis or result of the biopsy was?</th>
<th>Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Specify:</td>
<td>Specify:</td>
<td>Name of doctor Name of hospital/center/clinic City State DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City State DATE</td>
</tr>
<tr>
<td>2) Specify:</td>
<td>Specify:</td>
<td>Name of doctor Name of hospital/center/clinic City State DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City State DATE</td>
</tr>
<tr>
<td>3) Specify:</td>
<td>Specify:</td>
<td>Name of doctor Name of hospital/center/clinic City State DATE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>City State DATE</td>
</tr>
</tbody>
</table>
10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

A. Shingles (or herpes zoster)

   IF YES: Which month and year (since your last visit) did this episode of shingles (zoster) begin?

B. Thrush (yeast in your mouth)

   IF YES: Which month and year (since your last visit) did this episode of thrush begin?

C. Infectious mononucleosis

D. Sinusitis, a sinus infection that requires antibiotics

E. Bronchitis

F. Pancreatitis

G. Prostate Problems

H. High blood pressure or hypertension

I. Injury to head with loss of consciousness

J. Chest pain or angina

K. Heart attack

L. Congestive heart failure or CHF

M. Stroke or CVA

N. Seizure

O. Osteoporosis (bone thinning)

P. Arthritis

   IF YES: Was it:

   Rheumatoid

   Osteoarthritis or degenerative

   Other

Q. Avascular necrosis, osteonecrosis, or had a hip replacement

R. Kidney disease/Renal failure

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

   Hepatitis B or serum hepatitis

   Hepatitis C

T. Liver disease

   GET MEDICAL RELEASE

   IF YES: Was it:

   Cirrhosis

   Fibrosis

   Inflammation

   Elevated liver function test/enzyme

   Other

   Don’t know

   Specify:

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

   Name of hospital/clinic or doctor

   Address

   City State

   Date of diagnosis

U. [Since your last visit in (MONTH)] Have you received an injection of pneumococcal vaccine/Pneumovax?

V. [Since your last visit in (MONTH)] Have you received an injection of hepatitis B vaccine or combination of A and B vaccine (Twinrix)?

W. [Since your last visit in (MONTH)] Have you received an injection of hepatitis A vaccine or combination of A and B vaccine (Twinrix)?

X. [Since your last visit in (MONTH)] Has a doctor or other medical practitioner told you that you had sickle cell anemia?

Y. [Since your visit in (MONTH)] Have you had any neurological evaluation or a physical examination, in addition to this study, to look for problems of the nervous system?

   IF YES: Was there a diagnosis for your condition?

   IF YES: What was the diagnosis?

   Specify:

   Other

   Don’t know

   Specify:

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

   Name of hospital/clinic or doctor

   Address

   City State

   Date of diagnosis
Z. [Since your last visit in (MONTH)] Have you seen a doctor or other medical practitioner for any (other) conditions or problems in the following areas?

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

b) Ears, Nose, Throat, Mouth
   IF YES: Was there a diagnosis?
   What was the diagnosis?

c) Heart
   IF YES: Was there a diagnosis?
   What was the diagnosis?

d) Lungs
   IF YES: Was there a diagnosis?
   What was the diagnosis?

e) Stomach and Intestines
   IF YES: Was there a diagnosis?
   What was the diagnosis?

f) Bones, Joints or Muscles
   IF YES: Was there a diagnosis?
   What was the diagnosis?

Specify:

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

f) Genital and Urinary
   IF YES: Was there a diagnosis?
   What was the diagnosis?

Specify:

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

h) Skin
   IF YES: Was there a diagnosis?
   What was the diagnosis?

Specify:

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

i) Nervous system
   IF YES: Was there a diagnosis?
   What was the diagnosis?

Specify:

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

j) Psychological
   IF YES: Was there a diagnosis?
   What was the diagnosis?

Specify:

1) 10 20 30 40 50 60 70 80 90
2) 1 2 3 4 5 6 7 8 9
11A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, [since your visit in MONTH]? 

<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 12

B. Did the first attack of herpes you ever had occur since your visit in (MONTH)?   

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

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

<table>
<thead>
<tr>
<th>DISEASE OR CONDITION</th>
<th>HAD DISEASE</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>A) Syphilis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>B) Any form of gonorrhea</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>C) Urethral gonorrhea  (clap or drip of the urinary passage)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>D) Oral gonorrhea  (of the mouth or throat)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>E) Rectal gonorrhea  (of the rectum)</td>
<td></td>
<td></td>
<td></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></td>
<td></td>
<td></td>
</tr>
<tr>
<td>G) Genital warts or anal warts (condylomata acuminata)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>H) Chlamydia</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify:
### PROBLEM OR SYMPTOM
FOR EACH “YES” IN a
ASK b, c, d, AND e.

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>How about (EACH)? Did you have that at any time (since your visit in (MONTH))?</th>
<th>Did that last for two weeks or longer?</th>
<th>And do you have that now?</th>
<th>Is this a new condition? IF NO, GO TO NEXT ROW</th>
<th>WHEN BEGAN (Month and Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Persistent dizziness for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>3) Persistent or recurring fever higher than 100° for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>7) Diarrhea for at least 3 consecutive days</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>8) Drenching sweats at night on at least 3 occasions</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>9) Nausea, vomiting</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>10) Abdominal pain, bloating, cramps</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>11) Ascites (fluid buildup in the stomach or abdomen)</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>13) An unusual bruise or bump or skin discoloration that lasted at least two weeks</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>15) Anemia, low RBC, low hemoglobin</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>16) Blood in urine</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
</tbody>
</table>
13.A. Continued

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM FOR EACH “YES” IN a. ASK b. c. d. AND e.</th>
<th>How about (EACH)? Did you have that at any time (since your last visit in (MONTH))?</th>
<th>Did that last for two weeks or longer?</th>
<th>And do you have that now?</th>
<th>Is this a new condition? IF NO, GO TO NEXT ROW</th>
<th>WHEN BEGAN (Month and Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) Unusual bleeding or bleeding that is difficult to stop</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>18) Muscle pain or weakness</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>19) Joint pain</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>20) Painful urination</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>21) Kidney stones</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>22) High blood sugar, diabetes (We mean a new diagnosis or an uncontrolled condition.)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>23) High cholesterol, high triglycerides or high lipids (We mean a new diagnosis or an uncontrolled condition.)</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>24) Fat maldistribution or abnormal changes in body fat</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>25) Vivid nightmares or dreams</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
<tr>
<td>26) Insomnia or problems sleeping</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Severity (0= None, 1= Mild, 10= Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Right</strong></td>
</tr>
<tr>
<td><strong>Left</strong></td>
</tr>
<tr>
<td>Pain, aching, or burning in your feet or legs?</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Pins and needles in your feet or legs?</td>
</tr>
<tr>
<td>NO</td>
</tr>
<tr>
<td>Numbness (lack of feeling) in your feet or legs?</td>
</tr>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>
### 14. A. [Since your visit in (MONTH)] Has a doctor or other medical practitioner tested your blood to see if you have HIV that is resistant to certain drugs?
- No  [SKIP TO Q 15]
- Yes  [SKIP TO Q 15]

### 14. B. What type of test was done?
1. **Phenotype**
2. **Genotype**

### 14. C. Has your treatment (drugs) been changed as a result of that test?
- No  
- Yes  [SKIP TO Q 15.B (1)]

### 15. Since your last visit, have you taken any HIV-related medications or treatments? (That is, medications or treatments to suppress or prevent getting sick because of HIV or to treat the sickness related to HIV or AIDS excluding acyclovir.)
- No  
- Yes  [SKIP TO Q 15.B (1)]

### 15.A. IF NO: Why did you decide not to take HIV-related medications?
READ EACH, MARK ALL THAT APPLY
- Not infected with HIV  [SKIP TO Q 16]
- 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 16]

### 15.B. (1) [Since your last visit (MONTH)] Have you taken any medication or drug on this list (SHOW LIST 1 AND MEDICATION PHOTO CARDS)?
- No  
- Yes  [SKIP TO Q 15.B (3)]

**SHOW LIST 1 AND MEDICATION PHOTO CARDS**

### 15.B. (2) IF NO: Why did you decide not to take 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:  [SKIP TO Q 15.C]

### 15.B. (3) Please name those drugs that you have taken or show me which ones.
FILL IN THE BUBBLE NEXT TO THE DRUG(S).

- 3-TC (Epivir, Lamivudine)
- Abacavir (Ziagen)
- Amprenavir (Agenerase)
- AZT (Retrovir, Zidovudine)
- Atazanavir (BMS-232632)
- Combivir (AZT & 3-TC)
- d4T (Zerit, Stavudine)
- ddI (dideoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Lopinavir/r (Kaletra)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Tenofovir (Viread)
- Trizivir (abacavir + zidovudine + lamivudine)
- T-20
- Other anti-viral from Drug List 1

**COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B(3)**

### 15.B. (4) [Since your last visit (MONTH)], did you stop taking all of your prescribed antiretroviral therapy for at least 2 days in a row?
- No  [SKIP TO Q 15.C]
- Yes

IF YES: How many times did this occur?

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

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

SERIAL #  [SKIP TO Q 15.C]
15.C. (1) [Since your last visit in (MONTH)] 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 15.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.)

COMPLETE FORM II FOR EACH DRUG MARKED ABOVE IN Q 15.C(1)

D. (1) [Since your last visit in (MONTH)] 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 16

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

(Report Acyclovir in Q16.)
16. 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 [since your visit in (MONTH)].

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

<table>
<thead>
<tr>
<th>QUESTION</th>
<th>IF &quot;NO&quot; TO a, GO TO NEXT ITEM</th>
<th>How about (EACH)? Have you (taken/used) any [since your visit in (MONTH)]?</th>
<th>When specified, what was the name of the (KIND OF DRUG) you took and what did you take this drug for?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Steroids that you took by mouth or were injected</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>2) Thyroid hormone or medication</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>3) Other hormones such as anabolic steroids</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>4) Antibiotics such as penicillin, tetracycline, erythromycin, or a sulfa drug</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>5) Medication taken by mouth for fungal infection</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>6) Medication taken by mouth for worms or parasites</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>7) Tranquilizers or sleeping pills</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>IF YES, have you taken/used any in the last 7 days?</td>
<td></td>
<td>NO YES, Yes</td>
<td>Name: Used for:</td>
</tr>
<tr>
<td>8) Antidepressants or mood elevators</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>9) Lithium</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex)</td>
<td></td>
<td>NO YES, Yes</td>
<td>Name: Used for:</td>
</tr>
<tr>
<td>IF YES, was this for:</td>
<td></td>
<td>NO YES, Yes</td>
<td>Name:</td>
</tr>
<tr>
<td>chronic herpes?</td>
<td></td>
<td>NO YES, Yes</td>
<td>Name:</td>
</tr>
<tr>
<td>episodic herpes?</td>
<td></td>
<td>NO YES, Yes</td>
<td>Name:</td>
</tr>
<tr>
<td>11) Viagra</td>
<td></td>
<td>NO YES</td>
<td>Name:</td>
</tr>
<tr>
<td>12) Cholesterol, triglycerides or lipid lowering medications</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td>a. (SPECIFY in column b)</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td>b. (SPECIFY in column b)</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td>c. (SPECIFY in column b)</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td>13) Medications used for diabetes</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
<tr>
<td>a. (SPECIFY in column b)</td>
<td></td>
<td></td>
<td>Name:</td>
</tr>
</tbody>
</table>
16. Continued

<table>
<thead>
<tr>
<th>Question</th>
<th>a. (SPECIFY in column b)</th>
<th>b. (SPECIFY in column b)</th>
<th>c. (SPECIFY in column b)</th>
<th>d. (SPECIFY in column b)</th>
<th>e. (SPECIFY in column b)</th>
<th>f. (SPECIFY in column b)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medications used for diabetes (cont.)</td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>13)</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>14) Hepatitis medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15) Other</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>c.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>d.</td>
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<tr>
<td>e.</td>
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<td></td>
</tr>
<tr>
<td>f.</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

When specified, what was the name of the (KIND OF DRUG) you look and what did you take this drug for?

How about (EACH)? Have you (taken/used) any (since your visit in (MONTH))?
17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?
   ○ No  [SKIT TO Q 18]  ○ 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

   ________________________________
   Date started trial

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

18.A. Since your last visit did you have [ASK EACH ITEM AND RECORD ANSWER] [NO YES]

  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) ADAP (AIDS Drug Assistance Program)  ○ ○
  9) Other  ○ ○ [Specify]

18.B. Do you have insurance coverage that pays for any of your medications? [NO YES]

IF NO TO Q 18.A (1)–(9) AND Q 18.B, THEN SKIP TO Q 22

19. A. Since your last visit, have you changed or lost your medical coverage?

B. IF YES, was that change your choice?  ○ ○

C. Did you change for any of the following reasons? [PLEASE ASK EACH QUESTION] [READ ALL CHOICES AND SELECT ONLY ONE]
   [NO YES]

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 19.C, ASK] Which one was the PRIMARY reason?

   ○ 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
19.E. Are you currently insured?
   ○ No → SKIP TO Q 22
   ○ Yes

20.A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)

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

B. [IF "YES" TO MORE THAN ONE RESPONSE IN Q20.A, ASK] What was the PRIMARY reason for choosing your current medical coverage? [READ ALL CHOICES AND SELECT ONLY ONE]
   ○ Employer offers only one plan
   ○ Only eligible for current coverage due to medical condition
   ○ To be able to choose doctors or providers
   ○ To have more or better coverage of needed or desired services
   ○ Eligible for Medicaid, Medi-Cal, or Medical Assistance
   ○ Financial reasons (cost of premiums, co-payments or deductibles)
   ○ Eligible for Medicare

21. 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

22. Did you have any type of dental insurance coverage at any time since your last visit in (MONTH)?
   ○ No
   ○ Yes

23. Where do you usually go for medical care, even if you haven’t received medical care since your last visit?
   [READ ALL CHOICES AND SELECT ONLY ONE]
   ○ HMO
   ○ Doctor’s office or specialty clinic (non-HMO) including Urgent Care
   ○ Any other clinic
   ○ Emergency room
   ○ Other outpatient

   Specify:
   ○ No regular source of medical care
   ○ Don’t know

24. Since your visit in (MONTH), 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) since your last visit?</th>
<th>How many times? (99 = 99 or more)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) HMO</td>
<td>NO → YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>2) Doctor’s office or specialty clinic (non-HMO) including Urgent Care</td>
<td>NO → YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>3) Any other clinic</td>
<td>NO → YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>4) Emergency room</td>
<td>NO → YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>5) Other outpatient</td>
<td>NO → YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
</tbody>
</table>

Specify:
25. Since your last visit in (MONTH), have you used ANY of the following providers or services?

<table>
<thead>
<tr>
<th>SERVICE</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></td>
</tr>
<tr>
<td>- NO</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>- YES</td>
<td></td>
</tr>
<tr>
<td>2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)</td>
<td></td>
</tr>
<tr>
<td>- NO</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>- YES</td>
<td></td>
</tr>
<tr>
<td>3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)</td>
<td></td>
</tr>
<tr>
<td>- NO</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>- YES</td>
<td></td>
</tr>
<tr>
<td>4) Any form of paid health care in your home (visiting nurse services, home health aides, but not care from lovers, family or friends)</td>
<td></td>
</tr>
<tr>
<td>- NO</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>- YES</td>
<td></td>
</tr>
</tbody>
</table>
26. Please estimate the **TOTAL** out-of-pocket expenses that you or other personal sources (your lover, family or friends) paid for prescription medications since your last visit in (MONTH). [ROUND TO NEAREST DOLLAR, CODE "0" IF LESS THAN $1]

| $ | 0 0 0 0 0 0 0 0 0 0 | OR | 0 0 0 0 0 0 0 0 0 0 |

27.A. Was there a time since your last visit in (MONTH) 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 28]
- Yes

B. IF YES: Was there a time that you did not seek (obtain) (READ EACH) you thought you needed?
1) Medical care
- No [SKIP 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 [SKIP 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 [SKIP TO Q 28]
- Yes
  - Why did you not obtain prescription medications?
  - [READ EACH AND MARK ALL THAT APPLY]
  - Financial reasons
  - Other non-financial reasons
  - Specify:

28. Was there a time since your last visit when you were refused care from a doctor or other medical provider?
- No
- Yes

29. Was there a time since your last visit when you were refused dental care?
- No
- Yes

30. At present, which of the following categories describes your annual individual gross income before taxes? [SHOW CARD TO PARTICIPANT OR READ ALOUD.]
- Less than $10,000
- 10,000–19,999
- 20,000–29,999
- 30,000–39,999
- 40,000–49,999
- 50,000–59,999
- 60,000 or more
- Does not wish to answer

31. Are you experiencing major financial difficulty meeting your basic expenses?
- No [SKIP TO Q 32]
- Yes

IF YES: Is the difficulty less, the same or greater than at your last visit in (MONTH)
- Less
- Same
- Greater

32. Since your last visit, has your employment status changed for any reason related to HIV disease?
- No [SKIP TO Q 33]
- Yes

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

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

33. Now I have some questions about cigarette smoking.
   A. Have you ever smoked cigarettes?
      ● No  SKIP TO Q 34
      ● Yes
   B. Do you smoke cigarettes now?
      (As of one month ago?)
      ● No  SKIP TO Q 34
      ● Yes
      ○ Occasionally (less than one cigarette per day)
   C. How many packs do you usually smoke per day?
      ● Less than 1/2 pack
      ● At least 1/2 pack; but less than one pack per day
      ● At least 1 but less than 2 packs
      ● 2 or more packs per day

34. The next questions are about alcoholic beverages—
    that is, wine, beer or liquor you’ve drunk [since your visit in (MONTH)].
   A. Did you drink any alcoholic beverages [since your visit in (MONTH)]?
      ● No  SKIP TO Q 34.D
      ● Yes
   B. How often do 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
      ● 3 to 4 times a week
      ● Once or twice a week
   C. [Since your visit in (MONTH)] 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.) Please turn to page 2 in your booklet for the possible answers to this.
      ● 1 or 2 drinks
      ● 3 or 4 drinks
      ● 5 or 6 drinks
      ● 7 or more drinks
   D. Have you ever been in an alcohol treatment program, including inpatient and/or outpatient 
      detox, alcoholics anonymous, and/or any other program?
      ● No
      ● Yes

READ DEFINITION OF SEXUAL ACTIVITY:
SEXUAL ACTIVITY includes oral sex, anal/butt sex, vaginal sex, and any touching of genital or anal areas, with or without ejaculation. This definition includes deep kissing.

35. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)]?
   ● No  SKIP TO Q 42
   ● Yes

36. Have you had any sexual activity with a woman since your last visit?
   ● No  SKIP TO Q 39
   ● Yes

37. Now let’s talk about how many different women you have had sexual activity with since your last visit.
   A. How many different women (if any) have you had sexual intercourse with since your last visit? Here we define sexual intercourse as inserting your penis into your partner’s mouth, vagina, or anus/butt, with or without ejaculation.
      ● 1 2 3 4 5 6 7 8 9
   B. With how many other women have you had sexual activity that did not include intercourse since your last visit?
      ● 1 2 3 4 5 6 7 8 9
The next questions are about different kinds of sexual activity men have with women.

**IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 38.10**

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>NO ☐ YES ☐</th>
<th>How many women did you do that with since your last visit? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) You put your penis in her mouth (oral sex).</td>
<td>NO ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>2) With how many of those women did you use a condom every time for oral sex, even if it broke, tore, or slipped?</td>
<td>NO ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>Did you use a condom every time you had oral sex even if it broke, tore, or slipped?</td>
<td>NO ☐ YES ☐</td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>3) With how many women did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO ☐ YES ☐</td>
<td></td>
</tr>
<tr>
<td>4) You put your penis in her vagina (vaginal sex).</td>
<td>NO ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>5) 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 ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td>NO ☐ YES ☐</td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>6) 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 ☐ YES ☐</td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>01 0 2 03 04 05 06 07 08 09 010 0 20 30 40 50 60 70 80 90 100 200 300 400 500 600 700 800 900</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 ☐ YES ☐</td>
<td></td>
</tr>
</tbody>
</table>
38. Continued

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a woman since your last visit?</th>
<th>How many women did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7) You put your penis in her anus/butt (anal sex). IF NONE, SKIP TO ITEM (10).</td>
<td>NO YES</td>
<td>0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10</td>
</tr>
<tr>
<td>8) 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>IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td>NO YES</td>
</tr>
<tr>
<td>9) 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>IF ONE PARTNER: Did you ejaculate/cum in her anus/butt when you did not use a condom (or when a condom failed)?</td>
<td>NO YES</td>
</tr>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (“rimming”).</td>
<td>NO YES</td>
<td>0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10</td>
</tr>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td>NO YES</td>
<td>0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10</td>
</tr>
</tbody>
</table>

39. Have you had any sort of sexual activity with a man since your last visit?

- No
- Yes

SKIP TO Q.42

40. Now let’s talk about how many different men you have had sexual activity with since your last visit.

A. How many different men (if any) have you had sexual intercourse with since your last visit? 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.

- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10

B. With how many other men have you had sexual activity that did not include intercourse since your last visit?

- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10
- 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 10

Page 21
The next questions are about different kinds of sexual activity some men engage in with other men.

**IF NO INTERCOURSE WITH MEN, SKIP TO Q 41.13**

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

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a man since your last visit?</th>
<th>How many men did you that with (since your last visit)? (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 (4).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<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</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td>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>NO</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<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</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td>Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</td>
<td>NO</td>
</tr>
<tr>
<td>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<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</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td>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>NO</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<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</td>
</tr>
</tbody>
</table>
41. **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 man since your last visit?</th>
<th>How many men did you do that with (since your last visit)? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</th>
</tr>
</thead>
<tbody>
<tr>
<td>7) He put his penis in your mouth.</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF NONE, SKIP TO ITEM (10).</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 men was a condom used every time, even if it broke, tore, or slipped?</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF ONE PARTNER: Thinking of the times when he put his penis in your mouth, was a condom used every time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</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 a condom (or when a condom failed)?</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF ONE PARTNER: Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10) He put his penis in your anus/butt.</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF NONE, SKIP TO ITEM (13).</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 many men was a condom used every time, even if it broke, tore, or slipped?</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF ONE PARTNER: Thinking of the times when he put his penis in your anus/butt, was a condom used every time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</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 use a condom (or when a condom failed)?</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
<tr>
<td>IF ONE PARTNER: Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>13) You used your tongue to touch or lick his anus/butt (“rimming”).</td>
<td>NO  YES</td>
<td>0  10  20  30  40  50  60  70  80  90</td>
</tr>
</tbody>
</table>
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 visit in (MONTH)]?

<table>
<thead>
<tr>
<th>Drug Type</th>
<th>How about (EACH) Have you (taken/used) any [since your visit in (MONTH)]?</th>
<th>How often did you (use/take) (DRUG) [since your visit in (MONTH)]?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pot, Marijuana or Hash</td>
<td>NO □ YES □</td>
<td>DAILY □ WEEKLY □ MONTHLY □ LESS OFTEN □</td>
</tr>
<tr>
<td>“Poppers” like nitrite inhalants (amyl, butyl or isopropyl nitrites)</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>DAILY □ WEEKLY □ MONTHLY □ LESS OFTEN □</td>
</tr>
<tr>
<td>Other forms of cocaine</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>DAILY □ WEEKLY □ MONTHLY □ LESS OFTEN □</td>
</tr>
<tr>
<td>Heroin</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>DAILY □ WEEKLY □ MONTHLY □ LESS OFTEN □</td>
</tr>
<tr>
<td>Ecstasy, XTC, X or MDMA</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>DAILY □ WEEKLY □ MONTHLY □ LESS OFTEN □</td>
</tr>
</tbody>
</table>

Specify:

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

Specify:

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

Specify:

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

Specify:

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

Specify:

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

Specify:

- Specify:
  - 0 [ ] 1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ] 9 [ ]
43. A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?
   - No
   - Yes

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
   - 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

44. [Since your last visit in (MONTH)] have you shared a needle or works with anyone? By works I mean needles, syringes and/or a cooker?
   - No
   - Yes

45. A. [Since your last visit in (MONTH)] 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

B. With how many different people?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9

46. A. [Since your last visit in (MONTH)] have you shared water to rinse your needles with anyone?
   - No
   - Yes

B. How many times?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9

C. With how many different people?
   - 0
   - 1
   - 2
   - 3
   - 4
   - 5
   - 6
   - 7
   - 8
   - 9

47. [Since your last visit in (MONTH)] how often did you clean your works with bleach?
   - Never
   - Less than half the time
   - About half the time
   - Most of the time
   - Always

48. A. [Since your last visit in (MONTH)] have you participated in a needle exchange program?
   - No
   - 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
   - Most of the time
   - Always

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

49. [Since your last visit in (MONTH)] 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
50. A. Is there anything more that I haven't asked that you think we should know?
   - No, nothing more
   - Yes

51. ACASI interview?
   - No
   - Yes

52. Telephone interview?
   - No
   - Yes

53. Home visit?
   - No
   - Yes

54. PWA interview?
   - No
   - Yes
   - Don't know

55. Returning censored participant?
   - No
   - Yes

56. Date interview completed

57. Reporter’s signature

58. Are you of Hispanic (Spanish) or Latino origin?
   - No
   - Yes

59. What is your race? Do you consider yourself . . .? (Read each and mark all that apply.)
   - White
   - Black
   - Native Hawaiian (Pacific Islander)
   - Alaskan Native
   - Native American (North, South, Central) Indian
   - Asian
   - Other

TIME ENDED

INTERVIEWER’S NUMBER

SERIAL #