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 “NO” TO B.</th>
<th>A. Kaposi’s sarcoma or KS</th>
<th>B. Pneumocystis carinii pneumonia (PCP)</th>
<th>C. Other pneumonia, specify</th>
<th>D. Toxoplasmosis or Toxo infection</th>
<th>E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it?</th>
<th>F. Mycobacterial infection (MAC, MAI or atypical TB)</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
<td>NO</td>
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<tr>
<td></td>
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<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<td>NO</td>
<td>NO</td>
<td>YES</td>
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<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
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<td></td>
<td></td>
<td>NO</td>
<td>NO</td>
<td>YES</td>
<td>YES</td>
<td>YES</td>
</tr>
</tbody>
</table>

**MARKING INSTRUCTIONS**
- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make NO stray marks.
- DO NOT fold this form.
1. Continued

<table>
<thead>
<tr>
<th>a</th>
<th>In what month and year was it first diagnosed since your last visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>G. Lymphoma, specify</td>
<td>NO</td>
</tr>
<tr>
<td>Primary brain lymphoma</td>
<td>J F M A M J J A S O N D</td>
</tr>
<tr>
<td>Non-Hodgkin's</td>
<td>94 95 96 97 98 99 00 01 02 03 04 05</td>
</tr>
<tr>
<td>Other</td>
<td></td>
</tr>
<tr>
<td>Specify,</td>
<td></td>
</tr>
</tbody>
</table>

| H. Meningitis related to HIV or cryptococcal meningitis | NO | YES |
| J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |

| I. Candida or thrush, a yeast infection of the esophagus, not just your mouth | NO | YES |
| J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |

| J. Cryptosporidiosis | NO | YES |
| J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |

| K. Wasting Syndrome or severe weight loss | NO | YES |
| J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |

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

Name of hospital/clinic or doctor:

Address:

City State:

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 30.B to record the name and address of the physician who diagnosed the condition(s).

- No
- Yes

IF "YES": What was the diagnosis?

<table>
<thead>
<tr>
<th>a</th>
<th>In what month and year was it first diagnosed since your last visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Specify:</td>
<td>J F M A M J J A S O N D</td>
</tr>
<tr>
<td>94 95 96 97 98 99 00 01 02 03 04 05</td>
<td></td>
</tr>
</tbody>
</table>

| 2) Specify: | J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |

| 3) Specify: | J F M A M J J A S O N D |
| 94 95 96 97 98 99 00 01 02 03 04 05 |
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>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>1M 2M 3M 4M 5M 6M 7M 8M 9M</td>
</tr>
<tr>
<td></td>
<td></td>
<td>J F M A M J J A S O N D</td>
</tr>
<tr>
<td></td>
<td></td>
<td>94 95 96 97 98 99 00 01 02 03 04 05</td>
</tr>
</tbody>
</table>

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

- Date

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**

4. B. **IF YES:** When was your last test?

- Date

4. 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**

5. B. Was the TB in your lungs?

- No
- Yes

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

- No
- Yes
6.A. [Since your last visit in (MONTH)] Have you been hospitalized overnight?

- [ ] No  [ ] Yes  **SKIP TO Q 7**

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

GET RELEASE OF RECORDS, NOTE NAME AND ADDRESS OF HOSPITAL

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

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

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

- [ ] No  [ ] Yes  [ ] Don’t know

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


Before 1989

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>1. High Cholesterol/Lipids</th>
<th>NO</th>
<th>YES</th>
<th>DON'T KNOW</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>2. High Blood Sugar/Diabetes</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. High Blood Pressure</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Stroke</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Chest Pain</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Heart Attack Before 60</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. Broken Hip Before 60</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. Pancreatitis</td>
<td>0</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Cancer</td>
<td>0</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)]?

   0 1 2 3 4 5 6 7 8 9 TIMES

C. For each biopsy, please tell me:

   a. Where in your body?

   - Specify:
   - Specify:
   - Specify:

   b. What did they say the diagnosis or result of the biopsy was?

   - Specify:
   - Specify:
   - Specify:

   c. Name of the doctor who performed the biopsy, where the biopsy was performed and the date of the biopsy?

   - Name of doctor
   - Name of hospital/center/clinic
   - City
   - State
   - DATE
10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

A. Shingles (or herpes zoster) NO YES

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

B. Thrush (yeast in your mouth) NO YES

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

C. Infectious mononucleosis NO YES

D. Sinusitis, a sinus infection that requires antibiotics NO YES

E. Bronchitis NO YES

F. Pancreatitis NO YES

G. Prostate Problems NO YES

H. High blood pressure or hypertension NO YES

I. Injury to head with loss of consciousness NO YES

J. Chest pain or angina NO YES

K. Heart attack NO YES

L. Congestive heart failure or CHF NO YES

M. Stroke or CVA NO YES

N. Seizure NO YES

O. Osteoporosis (bone thinning) NO YES

P. Arthritis NO YES

IF YES: Was it:

Rheumatoid

Osteoarthritis or degenerative

Other

Q. Avascular necrosis, osteonecrosis, or had a hip replacement NO YES

R. Kidney disease/Renal failure NO YES

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 NO YES

Hepatitis B or serum hepatitis NO YES

Hepatitis C NO YES

T. Liver disease

GET MEDICAL RELEASE

IF YES: Was it:

Cirrhosis NO YES

Fibrosis NO YES

Inflammation NO YES

Elevated liver function test/enzyme NO YES

Other

Specify:

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 last 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: What was the diagnosis?

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

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

[Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?
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?

- **g) Genital and Urinary**  
  If YES: Was there a diagnosis?  
  What was the diagnosis?

- **h) Skin**  
  If YES: Was there a diagnosis?  
  What was the diagnosis?

- **i) Nervous system**  
  If YES: Was there a diagnosis?  
  What was the diagnosis?

- **j) Psychological**  
  If YES: Was there a diagnosis?  
  What was the diagnosis?
11. A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, [since your visit in (MONTH)]?

- 1) Facial herpes, cold sores, or fever blisters
- 2) Sores in genital region
- 3) Sores in the anal or rectal areas
- 4) Sores elsewhere on your body

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

Specify:
13.A. [Since your visit in (MONTH)] Have you had any of the following problems or symptoms?

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>0</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>
<th>13</th>
<th>14</th>
<th>15</th>
<th>16</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
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<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
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<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
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<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
<td>M</td>
<td>A</td>
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<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
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<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</td>
</tr>
<tr>
<td>9) Nausea, vomiting</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
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<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
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<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</td>
</tr>
<tr>
<td>16) Blood in urine</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>NO</td>
<td>YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>J</td>
<td>F</td>
<td>M</td>
<td>A</td>
<td>M</td>
<td>J</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>a. How about (EACH)? Did you have that at any time (since your visit in (MONTH))?</th>
<th>b. Did that last for two weeks or longer?</th>
<th>c. And do you have that now?</th>
<th>d. Is this a new condition? IF NO, GO TO NEXT ROW</th>
<th>e. In what month and year since your last visit did it begin? [IF NEEDED: Even though you don’t remember the exact month, it would help if you could tell me the season or approximate time of year when it started (this last time)].</th>
</tr>
</thead>
<tbody>
<tr>
<td>17) Unusual bleeding or bleeding that is difficult to stop</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>WHEN BEGAN (Month and Year)</td>
</tr>
<tr>
<td>18) Muscle pain or weakness</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>19) Joint pain</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>20) Painful urination</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>21) Kidney stones</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>22) High blood sugar, diabetes (We mean a new diagnosis or an uncontrolled condition.)</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>23) High cholesterol, high triglycerides or high lipids (We mean a new diagnosis or an uncontrolled condition.)</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>24) Fat maldistribution or abnormal changes in body fat</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>25) Vivid nightmares or dreams</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
<tr>
<td>26) Insomnia or problems sleeping</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td>NO     YES</td>
<td></td>
</tr>
</tbody>
</table>

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

If NO, go to next question.
If YES, indicate severity.

<table>
<thead>
<tr>
<th>Severity (0= None, 1= Mild, 10= Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Right</td>
</tr>
<tr>
<td>Left</td>
</tr>
</tbody>
</table>

1. Pain, aching, or burning in your feet or legs?

2. Pins and needles in your feet or legs?

3. Numbness (lack of feeling) in your feet or legs?
14. 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 treat the sickness related to HIV or AIDS excluding acyclovir.)

- No
- Yes ➔ SKIP TO Q 15.A (1)

14.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

SKIP TO Q 16

15.A (1) [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.B (1)
- Yes

(2) What type of test was done?

1) Phenotype
2) Genotype

(3) Has your treatment (drugs) been changed as a result of that test?

- No
- Yes
- Don’t know

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)

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)
- ddC (dideoxycytidine, HIVID, Zalcitabine)
- ddI (dideoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Lopinavir/r (Kaletra)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Tenofovir (Viread)
- Trazavir (abacavir + zidovudine + lamivudine)
- T-20
- Other anti-viral from Drug List 1

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:

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

- No
- Yes ➔ SKIP TO Q 15.C

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?

1) 0 10 20 30 40 50 60 70 80 90
2) 0 10 20 30 40 50 60 70 80 90
3) 0 10 20 30 40 50 60 70 80 90

15.C. (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)
- ddC (dideoxycytidine, HIVID, Zalcitabine)
- ddI (dideoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Lopinavir/r (Kaletra)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Tenofovir (Viread)
- Trazavir (abacavir + zidovudine + lamivudine)
- T-20
- Other anti-viral from Drug List 1

15.C (2) IF YES: How many times did this occur?

- No
- Yes

Specify:

15.C (3) For how many days did you stop during the last time?

- No
- Yes

Specify:

COMPLETE FORM I FOR EACH DRUG MARKED ABOVE IN Q 15.B (3)
(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 (BW566C80, Mepron)
- Azithromycin (Zithromax)
- Bactrim (Sepra, SMZ-TMP, Sulfamethoxazole)
- Ciprofloxacin (CIPRO)
- Clarithromycin (Biaxin)
- Co-enzyme Q
- Colony stimulating factors (GM-CSF, G-CSF, Neupogen)
- Cortisone
- Dapsone
- DHEA
- Ethambutol (Myambutal)
- Erythropoietin (Epogen, Procrit)
- Flagyl (metronidazole)
- Fluconazole (Diffucan)
- Ganciclovir (DHPG, Cytovene)
- Hydroxyurea (Hydrea)
- Interleukin-2 (IL-2)
- Itraconazole (Sporonox)
- Ketoconazole (Nizoral)
- Megace
- Mycelx (clotrimazole)
- NAC (N-acetyl-cysteine)
- Oxadron (Oxandrolone)
- Pentamidine (aerosolized)
- Rifabutin (Ansamycin, Mycobutin)
- Serostim
- Testosterone (Delatestryl, Virilon, Testoderm, Androderm, Androgel)
- Vaccine trial (generic)
- Other from Drug List 2 (Report Acyclovir in Q 16.)

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

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

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

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

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

**ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 15a)**

**NO** | **YES**
---|---

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

**SKIP TO Q 16.14**

**c. (SPECIFY in column b)**

**SKIP TO Q 16.14**

**d. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**e. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**f. (SPECIFY in column b)**

**SKIP TO Q 17**

**ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 15a)**

**NO** | **YES**
---|---

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

**SKIP TO Q 16.14**

**c. (SPECIFY in column b)**

**SKIP TO Q 16.14**

**d. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**e. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**f. (SPECIFY in column b)**

**SKIP TO Q 17**

**ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 15a)**

**NO** | **YES**
---|---

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

**SKIP TO Q 16.14**

**c. (SPECIFY in column b)**

**SKIP TO Q 16.14**

**d. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**e. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**f. (SPECIFY in column b)**

**SKIP TO Q 17**

**ASK EACH ITEM UNTIL FIRST “NO” TO OTHER DRUG (ITEM 15a)**

**NO** | **YES**
---|---

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

**SKIP TO Q 16.14**

**c. (SPECIFY in column b)**

**SKIP TO Q 16.14**

**d. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**e. (SPECIFY in column b)**

**SKIP TO Q 16.15**

**f. (SPECIFY in column b)**

**SKIP TO Q 17**

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

**Name:**

**Used for:**

**Name:**

**Used for:**

**Name:**

**Used for:**

**Name:**

**Used for:**

**Name:**

**Used for:**
17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?

No [ ] 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]

[ ] Coverage by an HMO

[ ] Private insurance through a group (Blue Cross, CIGNA, etc.) (not as a HMO)

[ ] Individual private insurance (Blue Cross, CIGNA, etc.) (not as a HMO)

[ ] Medicaid, Medi-Cal, or Medical Assistance

[ ] Medicare (for people over 65 or permanently disabled)

[ ] Health care benefits for The Armed Forces or Veteran’s Administration

[ ] CHAMPUS or CHAMP-VA, medical insurance for dependents of military personnel or survivors of disabled veterans

[ ] ADAP (AIDS Drug Assistance Program)

[ ] 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?

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]

[ ] 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

D. [IF “YES” TO MORE THAN ONE RESPONSE IN Q 19.C, ASK] Which one was the PRIMARY reason? [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

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19.E. Are you currently insured?

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

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
2) Only eligible for current coverage due to medical condition
3) To be able to choose doctors or providers
4) To have more or better coverage of needed or desired services
5) Eligible for Medicaid, Medi-Cal, or Medical Assistance
6) Financial reasons (cost of premiums, co-payments or deductibles)
7) 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 GO TO NEXT ROW</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td>2) Doctor’s office or specialty clinic</td>
<td>NO GO TO NEXT ROW</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td>(non-HMO) including Urgent Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) Any other clinic</td>
<td>NO GO TO NEXT ROW</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td>4) Emergency room</td>
<td>NO GO TO NEXT ROW</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td>5) Other outpatient</td>
<td>NO GO TO Q 25</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
</tbody>
</table>

Specify:

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

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

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>Have you used (EACH) since your last visit in (MONTH)?</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 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)</td>
<td>☐ NO [GO TO NEXT ROW]</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td>0 1 2 3 4 5 6 7 8 9</td>
</tr>
<tr>
<td>3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)</td>
<td>☐ NO [GO TO NEXT ROW]</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td>0 1 2 3 4 5 6 7 8 9</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>☐ NO [GO TO Q 26]</td>
<td>0 10 20 30 40 50 60 70 80 90</td>
</tr>
<tr>
<td></td>
<td>☐ YES</td>
<td>0 1 2 3 4 5 6 7 8 9</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]

<table>
<thead>
<tr>
<th>$</th>
<th>0</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>
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<td>☐</td>
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<td>☐</td>
</tr>
</tbody>
</table>
> OR

☐ Don’t know
☐ Refused

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  
☐ Yes  

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

1) Medical care

☐ No  
☐ 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  
☐ 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  
☐ 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.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 31**

B. Tell me about it.

RECORD FULLY IN R’s OWN WORDS.

________________________________________

________________________________________

________________________________________

________________________________________

________________________________________

31. ACASI interview?

☐ No  
☐ Yes

32. Telephone interview?

☐ No  
☐ Yes

33. Home visit?

☐ No  
☐ Yes
34. PWA interview?
- No
- Yes
- Don’t know

35. Returning censored participant?
- No
- Yes

36. Date interview completed

37. Interviewer’s signature

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

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

40. 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

41. Are you experiencing major financial difficulty meeting your basic expenses?
- No - SKIP TO Q 42
- Yes

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

42. Since your last visit, has your employment status changed for any reason related to HIV disease?
- No - SKIP TO Q 43
- Yes

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

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

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.

43. Now I have some questions about cigarette smoking.
   A. Have you ever smoked cigarettes?
      ○ No  SKIP TO Q 44
      ○ Yes
   B. Do you smoke cigarettes now?
      (As of one month ago?)
      ○ No  SKIP TO Q 44
      ○ Occasionally (less than one cigarette per day)
      ○ Yes  SKIP TO Q 44
   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

44. 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 44.D
      ○ 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.

44.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

      ○ 2 or 3 times a month
      ○ About once a month
      ○ 6–11 times a year
      ○ 1–5 times a year

   C. [Since your visit in (MONTH)] On days when you drank any alcoholic beverages, how many drinks did you USAUALLY 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

45. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)]?
      ○ No  SKIP TO Q 52
      ○ Yes

46. Have you had any sexual activity with a woman since your last visit?
      ○ No  SKIP TO Q 49
      ○ Yes

47. 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.

   B. With how many other women have you had sexual activity that did not include intercourse since your last visit?
The next questions are about different kinds of sexual activity men have with women.

**IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 48.10**

48. **IF ONLY ONE PARTNER:** USE COLUMN a.

**IF MULTIPLE PARTNERS:** USE COLUMN b.

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>b</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>1)</strong> You put your penis in her mouth (oral sex).</td>
<td>[ ] Did you do this/engage in this activity with a woman since your last visit?</td>
<td></td>
</tr>
<tr>
<td><strong>IF NONE, SKIP TO ITEM (4).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>2)</strong> 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>[ ] How many women did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> Did you use a condom every time you had oral sex even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong> 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>[ ] How many women did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> Did you ejaculate/cum in her mouth when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>4)</strong> You put your penis in her vagina (vaginal sex).</td>
<td>[ ] Did you do this/engage in this activity with a woman since your last visit?</td>
<td></td>
</tr>
<tr>
<td><strong>IF NONE, SKIP TO ITEM (7).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>5)</strong> 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>[ ] How many women did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>6)</strong> 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>[ ] How many women did you do that with [since your last visit]? (Give me the actual number) (IF NEEDED: What’s your best estimate?)</td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
48. Continued

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>0</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>
</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</td>
<td>YES</td>
<td>0</td>
<td>100</td>
<td>200</td>
<td>300</td>
<td>400</td>
<td>500</td>
<td>600</td>
<td>700</td>
</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? IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td>NO</td>
<td>YES</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</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)? 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</td>
<td>YES</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
<td>7</td>
</tr>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (&quot;rimming&quot;).</td>
<td>NO</td>
<td>YES</td>
<td>0</td>
<td>100</td>
<td>200</td>
<td>300</td>
<td>400</td>
<td>500</td>
<td>600</td>
<td>700</td>
</tr>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td>NO</td>
<td>YES</td>
<td>0</td>
<td>100</td>
<td>200</td>
<td>300</td>
<td>400</td>
<td>500</td>
<td>600</td>
<td>700</td>
</tr>
</tbody>
</table>

49. Have you had any sort of sexual activity with a man since your last visit?  
○ No  [SKIP TO Q 52]  ○ Yes

50. 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.

B. With how many other men have you had sexual activity that did not include intercourse since your last visit?
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 51.13**

51. **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/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>1) You put your penis in his mouth. <strong>IF NONE, SKIP TO ITEM (4).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) <strong>IF MULTIPLE PARTNERS:</strong> 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></td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> 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></td>
</tr>
<tr>
<td>3) <strong>IF MULTIPLE PARTNERS:</strong> 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></td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong> Did you ejaculate/cum in his mouth when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) **YOU PUT YOUR PENIS IN HIS ANUS/BUTT. <strong>IF NONE, SKIP TO ITEM (7).</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5b.) 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></td>
<td></td>
</tr>
<tr>
<td><strong>If #5b &lt; #4 then read:</strong> Of the men you did not use a condom with,</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5b.1) Were any of these men HIV positive?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5b.2) Were any of these men HIV negative?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5b.3) Were you unsure of the HIV status of any of these men?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>(Mark Yes if 5b.1 or 5b.2 = Don’t Know)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5a.) Thinking of the times you put your penis in his anus/butt, did you use a condom every time, even if it broke, tore, or slipped?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>If 5a = No,</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5a.1) What was the HIV status of your partner when you did not use a condom?</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>IF MULTIPLE PARTNERS:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6b.) 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></td>
<td></td>
</tr>
<tr>
<td><strong>IF ONE PARTNER:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6a.) Did you ejaculate/cum in his anus/butt when you did not use a condom (or when a condom failed)?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Kind of Activity

<table>
<thead>
<tr>
<th>7) He put his penis in your mouth.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF NONE, SKIP TO ITEM (10).</td>
</tr>
</tbody>
</table>

#### If Only One Partner: Use Column a.

<table>
<thead>
<tr>
<th>Did you do this/engage in this activity with a man since your last visit?</th>
</tr>
</thead>
<tbody>
<tr>
<td>NO</td>
</tr>
</tbody>
</table>

#### How Many Men Did You Do That With Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

#### If Multiple Partners: Use Column b.

<table>
<thead>
<tr>
<th>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?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF ONE PARTNER:</td>
</tr>
<tr>
<td>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>
</tr>
</tbody>
</table>

| NO | YES |

#### How Many Men Did You Do That Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>9) With how many men did ejaculate/cum go into your mouth when they did not use a condom (or when a condom failed)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF ONE PARTNER:</td>
</tr>
<tr>
<td>Did ejaculate/cum go into your mouth when he did not use a condom (or when a condom failed)?</td>
</tr>
</tbody>
</table>

#### How Many Men Did You Do That Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>10) He put his penis in your anus/butt.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF NONE, SKIP TO ITEM (13).</td>
</tr>
</tbody>
</table>

#### If Only One Partner: Use Column a.

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

#### How Many Men Did You Do That Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

#### If Multiple Partners: Use Column b.

<table>
<thead>
<tr>
<th>11b.) 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?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF ONE PARTNER:</td>
</tr>
<tr>
<td>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>
</tr>
</tbody>
</table>

| NO | YES |

#### How Many Men Did You Do That Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>12b.) With how many men did ejaculate/cum go into your anus/butt when they did not use a condom (or when a condom failed)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>IF ONE PARTNER:</td>
</tr>
<tr>
<td>Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
<th>DON’T KNOW</th>
</tr>
</thead>
</table>

#### How Many Men Did You Do That Since Your Last Visit? (Give me the actual number) (If Needed: What’s Your Best Estimate?)

<table>
<thead>
<tr>
<th>01 02 03 04 05 06 07 08 09 10</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
</tbody>
</table>
51. 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>13) You used your tongue to touch or lick his anus/butt (“rimming”).</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

IF participant has only one man since last visit (50A + 50B = 1), ask Q 51.14
more than 1 sex partner since last visit, skip to Q 51.15

51.14) You said you had (intercourse or sexual activity) with only one man [(since your visit in (MONTH)]. How would you describe this individual?

- Main partner or someone you have a longstanding relationship with, live with, or partner with
- Casual partner, one-time partner, or person with whom you have not developed a longstanding, close relationship with

51.15) You mentioned that you had sex with more than one man [(since your visit in (MONTH)]. Would you consider only one of these men to be a main partner or someone you have a longstanding relationship with, live with, or partner with?

- No
- Yes

51.16) Did you have unprotected anal intercourse with your main partner in the last 6 months?

- No
- Yes

51.17) What is the HIV status of your main partner?

- Negative
- Positive
- I don’t know

51.18) Many men meet new sexual partners through different sources and in different settings. Since your last MACS visit, have you met one or more new male sexual partners in any of the following settings?

a) on the internet
b) at a party (including a circuit party)
c) through an advertisement in a newspaper or other newsletter
d) at a bar
e) at a bath house
f) in a park or other outdoor public place
g) in a bathroom, bookstore, or other indoor public place
h) at a place where drugs were used or exchanged
i) other place not listed above
j) have not met any new partners in past 6 months
52. 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 Description</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</td>
<td>YES</td>
</tr>
<tr>
<td>“Poppers” like nitrite inhalants (amyl, butyl or isopropyl nitrites)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Crack or cocaine that you smoke</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Other forms of cocaine</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Speed, Meth or Ice</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Heroin</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Speedball (heroin and cocaine together)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Ecstasy, XTC, X or MDMA</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>Other kinds of street/club drugs</td>
<td>NO</td>
<td>YES</td>
</tr>
</tbody>
</table>

Specify:

- Specify: 0 1 2 3 4 5 6 7 8 9
- Specify: 0 1 2 3 4 5 6 7 8 9
- Specify: 0 1 2 3 4 5 6 7 8 9
- Specify: 0 1 2 3 4 5 6 7 8 9
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- Specify: 0 1 2 3 4 5 6 7 8 9
- Specify: 0 1 2 3 4 5 6 7 8 9
- Specify: 0 1 2 3 4 5 6 7 8 9
53.A. [Since your last visit in (MONTH)] have you injected recreational drugs (skin popped, shot up with a needle)?

- No
- Yes  SKIP TO Q 59

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  SKIP TO Q 56

D. Thinking about the period when you injected the most, how many times did you inject [DRUG] per month?

- Speedball (cocaine and heroin together)

- Cocaine by itself

- Heroin by itself

- Speed by itself

54. [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  SKIP TO Q 56
- Yes

55.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?

- B. With how many different people?

56.A. [Since your last visit in (MONTH)] have you shared water to rinse your needles with anyone?

- No  SKIP TO Q 57
- Yes

B. How many times?

- C. With how many different people?

57. [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

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

- No  SKIP TO Q 59
- Yes

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

- C. Do you have another source of clean needles?

- No
- Yes

59. [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

Interviewer Instructions:
Thank the participant.
Record the time ended on page 19.