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>Condition</th>
<th>Code(s)</th>
<th>Comment</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Kaposi’s sarcoma or KS</td>
<td>KAPOS_41</td>
<td></td>
</tr>
<tr>
<td>B. Pneumocystis carinii pneumonia (PCP)</td>
<td>PCP_41</td>
<td></td>
</tr>
<tr>
<td>C. Other pneumonia, specify</td>
<td>PNEUM_41</td>
<td></td>
</tr>
<tr>
<td>D. Toxoplasmosis or Toxo infection</td>
<td>TOXOP_41</td>
<td></td>
</tr>
<tr>
<td>E. Cytomegalovirus infection (CMV) in your eyes, lungs, colon, or other location. Where was it? CODE ALL THAT APPLY (DO NOT CODE “YES” IF ONLY CMV ANTIBODIES.)</td>
<td>CMV_41</td>
<td></td>
</tr>
<tr>
<td>F. Mycobacterial infection (MAC, MAI or atypical TB)</td>
<td>MAI_41</td>
<td></td>
</tr>
</tbody>
</table>

- Make dark marks that fill the circle completely.
- Make clean erasures.
- Make NO stray marks.
- DO NOT fold this form.
H. Meningitis related to HIV or cryptococcal meningitis

IF "NO" TO a, GO TO NEXT ROW

G. Lymphoma, specify
- Primary
- Non-Hodgkin
- Other

Specify:

LYBRN_41
LYNHK_41
LYMPO_41

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

CRPYM_41
CRPY_41

J. Cryptosporidiosis

CRYSM_41
CRYS_41

K. Wasting Syndrome or severe weight loss

WSYNM_41
WSYNY_41

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

Name of hospital/clinic or doctor

Address

City State

1. Continued

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? Record the name and address of the physician who diagnosed the condition(s) in above box.

No
Yes

If "YES": What was the diagnosis?

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

ADX1M_41
ADX1Y_41

ADX2M_41
ADX2Y_41

ADX3M_41
ADX3Y_41
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
- [X] Yes

**IF "NO," GO TO Q 4**

**CANCE_41**

- [ ] IF YES: Where in the body was the cancer and what kind of cancer did they say it was?

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

**CAN1T_41**

- [ ] CAN1M_41
- [ ] CAN1Y_41

**CAN2T_41**

- [ ] CAN2M_41
- [ ] CAN2Y_41

**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

**PPDV_41**

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

- [ ] PPDM_41
- [ ] PPDY_41

C. Was it positive?

- [ ] NO
- [ ] YES

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

- [ ] NO
- [ ] YES

B. Was the TB in your lungs?

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

**GET MEDICAL RELEASE**

**SERIAL #**
6.A. [Since your last visit in (MONTH)] Have you been admitted to the hospital for any reason? This includes overnight stays and outpatient procedures.

- [ ] No
- [ ] Yes

   [ ] SKIPTO Q 7

   HOSP_41

   How many separate times were you a patient in a hospital (since your visit in (MONTH))?

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

   NHOSP_41

   GET RELEASE OF RECORDS.
   NOTE NAME AND ADDRESS OF HOSPITAL

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

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

   [ ] M [ ] J [ ] A [ ]
   [ ] M [ ] J [ ] A [ ]
   [ ] 01 02 03 04 05 06 07 08 09 10 11 12
   [ ] 13 14 15 16 17 18 19 20 21 22 23 24
   [ ] 25 26 27 28 29 30 31

   HOS1M_41

   HOS1D_41

   HOS1Y_41

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

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

   HOS1N_41

   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

   ________________________________________________

   ________________________________________________

   ________________________________________________

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

   [ ] M [ ] J [ ] A [ ]
   [ ] M [ ] J [ ] A [ ]
   [ ] 01 02 03 04 05 06 07 08 09 10 11 12
   [ ] 13 14 15 16 17 18 19 20 21 22 23 24
   [ ] 25 26 27 28 29 30 31

   HOS2M_41

   HOS2D_41

   HOS2Y_41

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

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

   HOS2N_41

   HOSP_41

   HOSP_41

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

   ________________________________________________

   ________________________________________________

   ________________________________________________

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

   [ ] M [ ] J [ ] A [ ]
   [ ] M [ ] J [ ] A [ ]
   [ ] 01 02 03 04 05 06 07 08 09 10 11 12
   [ ] 13 14 15 16 17 18 19 20 21 22 23 24
   [ ] 25 26 27 28 29 30 31

   HOS1M_41

   HOS1D_41

   HOS1Y_41

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

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

   HOS1N_41

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

- [ ] No
- [ ] Yes

   [ ] SKIPTO Q 7

   PHOS2_41

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

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

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

   [ ] M [ ] J [ ] A [ ]
   [ ] M [ ] J [ ] A [ ]
   [ ] 01 02 03 04 05 06 07 08 09 10 11 12
   [ ] 13 14 15 16 17 18 19 20 21 22 23 24
   [ ] 25 26 27 28 29 30 31

   HOS2M_41

   HOS2D_41

   HOS2Y_41

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

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

   HOS2N_41

   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

   [ ] SKIPTO Q 7

   DEPR_41

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

   [ ] M [ ] J [ ] A [ ]
   [ ] M [ ] J [ ] A [ ]
   [ ] 01 02 03 04 05 06 07 08 09 10 11 12
   [ ] 13 14 15 16 17 18 19 20 21 22 23 24
   [ ] 25 26 27 28 29 30 31

   DEPRM_41

   DEPRY_41

   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
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Don’t Know</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. high cholesterol, high tryglycerides, high lipids or too much fat in your blood?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. high blood sugar or diabetes?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. high blood pressure or hypertension?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. a stroke or CVA?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. chest pain or angina related to heart disease?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. a heart attack or myocardial infarction (MI)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. congestive heart failure or CHF?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8. mini-strokes or transient ischemic attacks (TIA)?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. too fast, too slow, or irregular heart beat?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. any blood vessels (arteries) that were blocked or closed?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11. an operation to open blocked blood vessels in your heart or other areas?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. a blood clot in your legs?</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. a blood clot in your lungs?</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

8.B. I would like you to think about other conditions and procedures or treatments that you may have had in the past. Has a doctor or other medical practitioner ever told you that you had...

**GET MEDICAL RELEASE IF FIRST DIAGNOSIS WAS MADE IN PAST 6 MONTHS.**

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

- No
- Yes
- Don’t Know
8.D. Have any members of your immediate family suffered from cancer?  

**NO**  **YES**  **DON'T KNOW**  

IF YES:  

Was it:  

- **G**  
- **E**  
- **T**  
- **M**  
- **E**  
- **D**  
- **I**  
- **C**  
- **A**  
- **L**  
- **R**  
- **E**  
- **L**  
- **A**  
- **S**  

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

<table>
<thead>
<tr>
<th>Name of the doctor who performed the biopsy</th>
<th>Where the biopsy was performed</th>
<th>Date of the biopsy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

WHERE IN YOUR BODY?  

Specify:  

- Name of doctor  
- Name of hospital/center/clinic  
- City  
- State  
- Date  

8.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.)  

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

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

<table>
<thead>
<tr>
<th>Biopsy Number</th>
<th>Name of doctor</th>
<th>Name of hospital/center/clinic</th>
<th>City</th>
<th>State</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>BIOP1_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIOP2_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BIOP3_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **a.** Skin cancer  
- **b.** Colon cancer  
- **c.** Prostate cancer  
- **d.** Other cancer
10. [Since your visit in (MONTH)] Has a doctor or other medical practitioner told you that you had (EACH)?

<table>
<thead>
<tr>
<th>A. Shingles (or herpes zoster)</th>
<th>HERPZ_41</th>
</tr>
</thead>
<tbody>
<tr>
<td>B. Thrush (yeast in your mouth)</td>
<td>THRS_41</td>
</tr>
<tr>
<td>C. Infectious mononucleosis</td>
<td>MONO_41</td>
</tr>
<tr>
<td>D. Sinusitis, a sinus infection that requires antibiotics</td>
<td>SINUS_41</td>
</tr>
<tr>
<td>E. Bronchitis</td>
<td>BRONC_41</td>
</tr>
<tr>
<td>F. Pancreatitis</td>
<td>PANCS_41</td>
</tr>
<tr>
<td>G. Prostate Problems</td>
<td>PROST_41</td>
</tr>
<tr>
<td>H. High blood pressure or hypertension</td>
<td>HDINJ_41</td>
</tr>
<tr>
<td>I. Injury to head with loss of consciousness</td>
<td>ANEMA_41</td>
</tr>
<tr>
<td>J. Anemia, low RBC, low hemoglobin</td>
<td>SEZUR_41</td>
</tr>
<tr>
<td>K. Chest pain related to heart disease or angina</td>
<td>SEZUR_41</td>
</tr>
<tr>
<td>L. Heart attack or myocardial infarction (MI)</td>
<td>ARTHR_41</td>
</tr>
<tr>
<td>M. Congestive heart failure or CHF</td>
<td>OSTAR_41</td>
</tr>
<tr>
<td>N. Stroke or CVA</td>
<td>OTHAR_41</td>
</tr>
<tr>
<td>O. Seizure</td>
<td>DKWAR_41</td>
</tr>
<tr>
<td>P. Osteoporosis (bone thinning)</td>
<td>HIPNE_41</td>
</tr>
<tr>
<td>Q. Arthritis</td>
<td>KIDND_41</td>
</tr>
</tbody>
</table>

T. Hepatitis or blood test that was positive for hepatitis? [This includes going to the doctor for chronic hepatitis.]

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>HEPAT_41</td>
<td></td>
</tr>
</tbody>
</table>

IF YES: Was it: (Read and answer each.)

- Hepatitis A or infectious hepatitis
- Hepatitis B or serum hepatitis
- Hepatitis C

U. Liver disease

GET MEDICAL RELEASE

IF YES:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVDS_41</td>
<td></td>
</tr>
</tbody>
</table>

GET MEDICAL RELEASE

IF YES:

<table>
<thead>
<tr>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIVDC_41</td>
<td></td>
</tr>
</tbody>
</table>

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

IF YES: Was it: (Read and answer each.)

- Cirrhosis
- Fibrosis
- Inflammation
- Elevated liver function test/enzyme
- Other

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

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

Y. [Since your visit in (MONTH)] Have you 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?
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?
   Specify:
   NO YES

b) Ears, Nose, Throat, Mouth and Sinuses
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

c) Heart and Blood Vessels
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

d) Lungs and Bronchial Tubes
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

e) Stomach and Intestines
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

f) Bones, Joints or Muscles
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

G) Genital, Urinary and Rectal
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

h) Skin
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

i) Nervous system
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES

j) Psychological
   IF YES: Was there a diagnosis?
   What was the diagnosis?
   Specify:
   NO YES
01 0 2 03 04 05 06 07 08 09 01 0 2 03 04 05 06 07 08 09 01 0 2 03 04 05 06 07 08 09 01 0 2 03 04 05 06 07 08 09

Z. Continued

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

l) Blood and Fluids
   IF YES: Was there a diagnosis? What was the diagnosis?
   Specify:

m) Allergy and Immune system other than HIV infection
   IF YES: Was there a diagnosis? What was the diagnosis?
   Specify:

n) Other
   IF YES: Was there a diagnosis? What was the diagnosis?
   Specify:

11.A. Have you had any of the following forms of herpes, not including shingles or herpes zoster, [since your visit in MONTH]?  
     NO YES
     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)?

   DISEASE OR CONDITION
   A) Syphilis
   B) Any form of gonorrhea
   C) Urethral gonorrhea (clap or drip of the urinary passage)
   D) Oral gonorrhea (of the mouth or throat)
   E) Rectal gonorrhea (of the rectum)
   F) Non-specific or nongonococcal urethritis (that is, a discharge from the penis that’s not caused by gonorrhea)
   G) Genital warts or anal warts (condylomata acuminata)
   H) Chlamydia
   I) Any parasitic diseases including worms, shigellosis, salmonellosis, amoebic dysentery, or giardiasis

   Specify:

   IF YES
   IF YES
   IF YES
<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>How about EACH? Did you have that at any time since your visit in [MONTH]0?</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 YES, GO TO COLUMN E</th>
<th>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>1) Persistent dizziness for at least 3 consecutive days</td>
<td>DIZZI_41 DIZW_41 DIZNO_41 DIZNC_41</td>
<td>NO YES NO YES NO YES</td>
<td>WHEN BEGAN (Month and Year)</td>
<td>DIZM_41 DIZY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>2) Persistent fatigue (feeling tired all the time) for at least 3 consecutive days</td>
<td>FATIG_41 FAT2W_41 FATIN_41 FATNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>FATIM_41 FATY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>3) Persistent or recurring fever higher than 100° for at least 3 consecutive days</td>
<td>FEVER_41 FEV2W_41 FEVRN_41 FEVNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>FEVRM_41 FEVRY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>4) Persistent, frequent or unusual kinds of headaches for at least 3 consecutive days</td>
<td>HEADA_41 HED2W_41 HEADN_41 HEANC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>HEADM_41 HEADY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>5) A new skin condition, rash, or infection that lasted for at least 3 consecutive days</td>
<td>RASH_41 RAS2W_41 RASHN_41 RSHNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>RASHM_41 RASHY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>6) Tender or enlarged glands or lymph nodes (not counting your groin) for at least 3 consecutive days</td>
<td>GLAND_41 GLN2W_41 GLANN_41 GLANC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>GLANM_41 GLANY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>7) Diarrhea for at least 3 consecutive days</td>
<td>DIARR_41 DIA2W_41 DIARN_41 DIANC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>DIARM_41 DIARY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>8) Drenching sweats at night on at least 3 occasions</td>
<td>SWEAT_41 SWT2W_41 SWETN_41 SWENC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>SWETM_41 SWETY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>9) Nausea, vomiting</td>
<td>VOMIT_41 VOTW_41 VOTNO_41 VOTNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>VOTM_41 VOTY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>10) Abdominal pain, bloating, cramps</td>
<td>BLOAT_41 ABP2W_41 ABPNO_41 ABPNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>ABPM_41 ABPY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>11) Ascites (fluid buildup in the stomach or abdomen)</td>
<td>ASCIT_41 ASCW_41 ASCNO_41 ASCNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>ASCTM_41 ASCTY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>12) Jaundice (yellow hue to whites of eyes, dark urine or clay colored stools)</td>
<td>JDICE_41 JDI2W_41 JDIN_41 JDINC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>JDICM_41 JDICY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>13) An unusual bruise or bump or skin discoloration that lasted at least two weeks</td>
<td>BRUIS_41 BRUSN_41 BRUNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>BRUSM_41 BRUSY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>14) An unintentional weight loss of at least 10 pounds (unrelated to dieting)</td>
<td>WTLOS_41 WTLSN_41 WTLNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>WTLSM_41 WTLSY_41</td>
<td>00 05</td>
</tr>
<tr>
<td>15) Blood in urine</td>
<td>BLURN_41 BLU2W_41 BLUNO_41 BLUNC_41</td>
<td>NO YES NO YES NO YES</td>
<td></td>
<td>BLUM_41 BLUY_41</td>
<td>00 05</td>
</tr>
</tbody>
</table>
13.A. Continued

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

<table>
<thead>
<tr>
<th>PROBLEM OR SYMPTOM</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>NO</th>
<th>YES</th>
<th>WHEN BEGAN (Month and Year)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unusual bleeding or bleeding that is difficult to stop</td>
<td>BLEED_41</td>
<td>BLDNO_41</td>
<td>BLDNC_41</td>
<td>BLDM_41</td>
<td>BLDY_41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Muscle pain or weakness</td>
<td>MPAIN_41</td>
<td>MPW2W_41</td>
<td>MPWNO_41</td>
<td>MPWNC_41</td>
<td>MPWM_41</td>
<td>MPWY_41</td>
<td></td>
</tr>
<tr>
<td>Joint pain</td>
<td>JOINT_41</td>
<td>JNT2W_41</td>
<td>JNTNO_41</td>
<td>JNTNC_41</td>
<td>JOINM_41</td>
<td>JOINY_41</td>
<td></td>
</tr>
<tr>
<td>Painful urination</td>
<td>PURIN_41</td>
<td>URN2W_41</td>
<td>URNNO_41</td>
<td>URNNC_41</td>
<td>URNM_41</td>
<td>URNY_41</td>
<td></td>
</tr>
<tr>
<td>Kidney stones</td>
<td>STONE_41</td>
<td>KIDNO_41</td>
<td>KIDNC_41</td>
<td>KIDM_41</td>
<td>KIDY_41</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vivid nightmares or dreams</td>
<td>DREAM_41</td>
<td>NVD2W_41</td>
<td>NVDNO_41</td>
<td>NVDNC_41</td>
<td>NVDM_41</td>
<td>NVDY_41</td>
<td></td>
</tr>
<tr>
<td>Insomnia or problems sleeping</td>
<td>NSOM_41</td>
<td>IPS2W_41</td>
<td>IPSNO_41</td>
<td>IPSNC_41</td>
<td>IPSM_41</td>
<td>IPSY_41</td>
<td></td>
</tr>
</tbody>
</table>

13.B. [Since your last visit in (MONTH)]

Have you experienced:

<table>
<thead>
<tr>
<th>PROBLEM</th>
<th>NO</th>
<th>YES</th>
<th>Severity (0= None, 1= Mild, 10= Severe)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Pain, aching, or burning in your feet or legs?</td>
<td>FEETP_41</td>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>2. Pins and needles in your feet or legs?</td>
<td>PINSF_41</td>
<td>Right</td>
<td></td>
</tr>
<tr>
<td>3. Numbness (lack of feeling) in your feet or legs?</td>
<td>NUMBF_41</td>
<td>Right</td>
<td></td>
</tr>
</tbody>
</table>
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 medications?

READ EACH, MARK ALL THAT APPLY AND THE

- Not infected with HIV
- Doctor said was not necessary
- Not sick
- Too expensive
- Don’t think they work or will help
- Possible side effects
- Can’t take them the way the doctor wants several times during the day or won’t remember
- Other reason

15. (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

15.A (2) IF NO: Why did you decide not to take medications?

READ EACH, MARK ALL THAT APPLY AND THEN SKIP TO Q 15.C

- 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 several times during the day or won’t remember
- Other reason

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

- No — RSTCH_41
- 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 — SKIP TO Q 15.B (3)
- Yes

(2) IF NO: Why did you decide not to take HIV-related medications?

READ EACH, MARK ALL THAT APPLY AND THEN SKIP TO Q 15.C

- 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 several times during the day or won’t remember
- Other reason

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) AND THEN COMPLETE FORM 1 FOR EACH DRUG.

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

15.B (3) (CONTINUED) Please name those drugs that you have taken or show me which ones.

15.C (1) 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

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

15.C (2) Did your physician prescribe or agree to:

- No
- Yes

For how many days did you stop taking medication?

15.D (1) 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 — STOP
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  

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

STOP

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 DRUG FORM 2 FOR EACH DRUG.

- Atovaquone (BWS66C80, Mepron)
- Azithromycin (Zithromax)
- Bactrim (Septra, 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 (Diflucan)
- Ganciclovir (DHPG, Cytovene)
- Hydroxyurea (Hydrea)
- Interleukin-2 (IL-2)
- Itraconazole (Sporonox)
- Ketoconazole (Nizoral)
- Megace
- Mycelex (clotrimazole)
- NAC (N-acetyl-cysteine)
- Nandralone (Deca-Durabolin)
- Nystatin (Mycostatin)
- Oxandrin (Oxandrolone)
- Pentamidine (aerosolized)
- Rifabutin (Ansamycin, Mycobutin)
- Serostim
- Testosterone (Delatestryl, Virilon, Testoderm, Androderm, Androgel)
- Vaccine trial (generic)

Other from Drug List 2

No  
Yes

15.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.

STOP

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.

STOP

Page 13
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>Drug Type</th>
<th>Name</th>
<th>How about each?</th>
<th>When specified, what was the name of the (kind of drug) you took and what did you take this drug for?</th>
<th>Have you taken/used any in the past 5 days (for aspirin in the last week)?</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>
<td>Name:</td>
</tr>
<tr>
<td>2) Thyroid hormone or medication</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>3) Other hormones such as anabolic steroids</td>
<td></td>
<td>No/Yes</td>
<td>Name:</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>
<td>Name:</td>
</tr>
<tr>
<td>5) Medication taken by mouth for fungal infection</td>
<td></td>
<td>No/Yes</td>
<td>Name:</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>
<td>Name:</td>
</tr>
<tr>
<td>7) Tranquilizers or sleeping pills</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>8) Antidepressants or mood elevators</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>9) Lithium</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>10) Acyclovir, famciclovir or valacyclovir for herpes (zovirax famvir, valtrex)</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>IF YES, Was this for: chronic herpes? No/Yes</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>IF YES, was this for: episodic herpes? No/Yes</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>11) Viagra or other drugs for erectile dysfunction</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>12) Aspirin taken three days or more on a weekly basis</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>13) Cholesterol, triglycerides, lipid or any blood fat lowering medications</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>a.</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>b.</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>c.</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>14) Hypertension medications</td>
<td></td>
<td>No/Yes</td>
<td>Name:</td>
<td>Name:</td>
</tr>
<tr>
<td>15) Medications used for diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------------------------</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>a.</strong></td>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA1_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA1_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>b.</strong></td>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA2_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA2_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>c.</strong></td>
<td>Name:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA3_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>DIA3_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>16) Hepatitis medications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
</tr>
<tr>
<td>HEPI_41</td>
</tr>
<tr>
<td>HEP1_41</td>
</tr>
<tr>
<td><strong>b.</strong></td>
</tr>
<tr>
<td>HEP2_41</td>
</tr>
<tr>
<td>HEP2_41</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>17) Other</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a.</strong></td>
</tr>
<tr>
<td>ORG1_41</td>
</tr>
<tr>
<td>ORG1_41</td>
</tr>
<tr>
<td><strong>b.</strong></td>
</tr>
<tr>
<td>ORG2_41</td>
</tr>
<tr>
<td>ORG2_41</td>
</tr>
<tr>
<td><strong>c.</strong></td>
</tr>
<tr>
<td>ORG3_41</td>
</tr>
<tr>
<td>ORG3_41</td>
</tr>
<tr>
<td><strong>d.</strong></td>
</tr>
<tr>
<td>ORG4_41</td>
</tr>
<tr>
<td>ORG4_41</td>
</tr>
<tr>
<td><strong>e.</strong></td>
</tr>
<tr>
<td>ORG5_41</td>
</tr>
<tr>
<td>ORG5_41</td>
</tr>
<tr>
<td><strong>f.</strong></td>
</tr>
<tr>
<td>ORG6_41</td>
</tr>
<tr>
<td>ORG6_41</td>
</tr>
<tr>
<td><strong>g.</strong></td>
</tr>
<tr>
<td>ORG7_41</td>
</tr>
<tr>
<td>ORG7_41</td>
</tr>
<tr>
<td><strong>h.</strong></td>
</tr>
<tr>
<td>ORG8_41</td>
</tr>
<tr>
<td>ORG8_41</td>
</tr>
</tbody>
</table>

Ask each item until first "NO" to other drug (item 17a). When specified, what was the name of the (kind of drug) you took and what did you take this drug for? Have you (taken/used) any in the past 5 days (for aspirin in the last week)?
17.A. Since your visit in (MONTH), have you been given a vaccine against HIV in a trial?

○ No  →  SKIP TO Q 18

○ Yes  →  HIVAC_41

B. Do you know the name of the trial?

○ No

○ Yes  →  Specify

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

○ No  →  INSCH_41

○ Yes

B. If YES, was that change your choice?

18.A. Since your last visit, have you had any medical coverage, such as HMO coverage, Blue Cross, or Medicare?

○ No  →  MEDCV_41

○ Yes - did you have

1) Coverage by an HMO

HMOC_41

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

GPIC_41

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

IPIC_41

4) Medicaid, Medi-Cal, or Medical Assistance

MCAID_41

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

MCARE_41

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

VABEN_41

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

CHAMP_41

8) Other

OTHER_41

Specify:

○ 1  2  3  4  5  6  7  8  9

9) ADAP (AIDS Drug Assistance Program)

ADAP_41

B. Do you have insurance coverage that pays for any of your medications?

INSDQ_41

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

INCLJ_41

○ Changed job (employer or employment status)

INCCJ_41

○ Employer changed or dropped coverage

INCEM_41

○ Pre-existing medical condition limited choices

INCMC_41

○ To be able to choose doctors or providers

INCMD_41

○ More or better coverage of needed or desired services

INCCV_41

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

INCEL_41

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

INCFR_41

○ Eligible for Medicare

INCMIE_41

○ Other

INCOT_41

Specify:

○ 1  2  3  4  5  6  7  8  9

E. Are you currently insured?

INCUR_41

○ No  →  SKIP TO Q 22

○ Yes  →  GO TO Q 20A
20.A. Did any of the following reasons apply in choosing your current medical coverage? (PLEASE ASK EACH QUESTION)  

<table>
<thead>
<tr>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Employer offers only one plan</td>
<td>CINEM_41</td>
</tr>
<tr>
<td>2) Only eligible for current coverage due to medical condition</td>
<td>CINMC_41</td>
</tr>
<tr>
<td>3) To be able to choose doctors or providers</td>
<td>CINMD_41</td>
</tr>
<tr>
<td>4) To have more or better coverage of needed or desired services</td>
<td>CINC_41</td>
</tr>
<tr>
<td>5) Eligible for Medicaid, Medi-Cal, or Medical Assistance</td>
<td>CINEL_41</td>
</tr>
<tr>
<td>6) Financial reasons (cost of premiums, co-payments or deductibles)</td>
<td>CINFR_41</td>
</tr>
<tr>
<td>7) Eligible for Medicare</td>
<td>CINME_41</td>
</tr>
</tbody>
</table>

B. [IF "YES" TO MORE THAN ONE RESPONSE IN Q 20.A, ASK] What was the PRIMARY reason for choosing your current medical coverage? [READ ALL CHOICES AND SELECT 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) Slightly satisfied  
- 4) Neither satisfied nor dissatisfied  
- 5) Somewhat dissatisfied  
- 6) Slightly 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]
25. Since your last visit in (MONTH), have you used ANY of the following providers or services?

<table>
<thead>
<tr>
<th>SERVICE</th>
<th>DENTV_41</th>
<th>DHNUM_41</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Dental health care provider (such as dentist or dental hygienist)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>How many times? (99 = 99 or more)</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>USEMH_41</th>
<th>MHNUM_41</th>
</tr>
</thead>
<tbody>
<tr>
<td>2) Mental health care provider (psychologist, psychiatrist, social worker, other therapist/ counselor)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>How many times? (99 = 99 or more)</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>USEAO_41</th>
<th>AONUM_41</th>
</tr>
</thead>
<tbody>
<tr>
<td>3) Other health care provider (chiropractor, nutritionist, acupuncturist, herbalist)</td>
<td>NO</td>
<td>YES</td>
</tr>
<tr>
<td>How many times? (99 = 99 or more)</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>USEHC_41</th>
<th>HCNUM_41</th>
</tr>
</thead>
<tbody>
<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</td>
<td>YES</td>
</tr>
<tr>
<td>How many times? (99 = 99 or more)</td>
<td>0 5 10 15 20 25 30 35 40 45 50 55 60 65 70 75 80 85 90 95 100</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

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

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

1) Medical care

- No
- Yes

2) Dental care

- No
- Yes

3) Prescription Medications

- No
- Yes

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

30.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. Date interview completed

36. Interviewer’s signature

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

38. What is your race? Do you consider yourself . . .?  
- White - WHITE_41  
- Black - BLACK_41  
- Alaskan Native - ALSNA_41  
- Asian - ASIAN_41  
- Native Hawaiian (Pacific Islander) - NHPI_41  
- Native American (North, South, Central) - NAMIN_41  
- Other - OTHRR_41

39. At present, which of the following categories describes your annual individual gross income before taxes?  
- Less than $10,000 - INCOM_41  
- $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

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

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

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

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

1) Became too sick to work - TSICK_41  
2) HIV status became known to employer - STKNE_41  
3) HIV status became known to coworkers - STKNC_41  
4) Early retirement - RETRY_41  
5) Changed job as a personal decision - JOBPE_41  
6) To receive better health insurance benefits - JOBHE_41  
7) To receive better disability benefits - DISAB_41  
8) Other - JOBOT_41

 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.

42. Now I have some questions about cigarette smoking.
   A. Have you ever smoked cigarettes?
      ○ No   SKIP TO Q 43   ESMOK_41
      ○ Yes
   B. Do you smoke cigarettes now? (As of one month ago?)  SMOKN_41
      ○ No   SKIP TO Q 43
      ○ Yes
      ○ Occasionally (less than one cigarette per day)  SKIP TO Q 43
   C. How many packs do you usually smoke per day?
      ○ Less than 1/2 pack  PACKS_41
      ○ 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

43. The next set of questions are about alcoholic beverages. They may seem similar, but they are asked in a slightly different way.

   Please answer each of the following questions for the past 6 months.

   A. How often have you had drinks containing alcohol?
      ○ Never  STOP – SKIP TO Q 43K
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   B. During the past 6 months, how many drinks containing alcohol have you had on a typical day when you are drinking? (A “drink” is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.)  NADRNK_41
      ○ 1 or 2
      ○ 3 or 4
      ○ 5 or 6
      ○ 7 to 9
      ○ 10 or more
      ○ None
   C. During the past 6 months, how often have you had six or more drinks on one occasion? (A “drink” is defined as one 12-ounce beer, one 5-ounce glass of wine, or one mixed drink with 1 and 1/2 ounces of 80-proof hard liquor.)  DRNK6_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   D. How often during the past 6 months have you found that you were not able to stop drinking once you started?  NSDRK_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   E. How often during the past 6 months have you failed to do what was normally expected from you because of drinking?  FLDRK_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   F. How often during the past 6 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?  MODRNK_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   G. How often during the past 6 months have you had a feeling of guilt or remorse after drinking?  GDRNK_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   H. How often during the past 6 months have you been unable to remember what happened the night before because you had been drinking?  HDRNK_41
      ○ Never
      ○ Less than monthly
      ○ Monthly
      ○ Weekly
      ○ Daily or almost daily
   I. Have you or someone else been injured as a result of your drinking?  HDRNK_41
      ○ No
      ○ Yes, but not in the past 6 months
      ○ Yes, during the past 6 months
   J. Has a relative or friend, or doctor or other health worker been concerned about your drinking or suggested that you cut down?  CDRNK_41
      ○ No
      ○ Yes, but not in the past 6 months
      ○ Yes, during the past 6 months
   K. Have you ever been in an alcohol treatment program, including inpatient and/or outpatient detox, alcoholics anonymous, and/or any other program?  ALCTP_41
      ○ 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.

44. Have you engaged in any sort of sexual activities involving another person [since your visit in (MONTH)]?  SEXAV_41
   ○ No  SKIP TO Q 51
   ○ Yes
45. Have you had any sexual activity with a woman since your last visit?  SEXVF_41
   ○ No  SKIP TO Q 48
   ○ Yes

GO TO QUESTION 46 ON NEXT PAGE.
46. 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.

<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>1) You put your penis in her mouth (oral sex). IF NONE, SKIP TO ITEM (4).</td>
<td>NO OINF1_41 YES OINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></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 OINF1_41 YES OINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td></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 OINF1_41 YES OINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></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 OINF1_41 YES OINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td></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 OINF1_41 YES OINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
</tbody>
</table>

The next questions are about different kinds of sexual activity men have with women.

IF NO INTERCOURSE WITH WOMEN, SKIP TO Q 47.10

47. IF ONLY ONE PARTNER: USE COLUMN a.

IF MULTIPLE PARTNERS: USE COLUMN b.

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>Did you do this/engage in this activity with a woman 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>4) You put your penis in her vagina (vaginal sex). IF NONE, SKIP TO ITEM (7).</td>
<td>NO VINF1_41 YES VINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></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 VINF1_41 YES VINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you use a condom every time for vaginal sex, even if it broke, tore, or slipped?</td>
<td>NO VINF1_41 YES VINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></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 VINF1_41 YES VINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Did you ejaculate/cum in her vagina when you did not use a condom (or when a condom failed)?</td>
<td>NO VINF1_41 YES VINF1_41</td>
<td>0 1 2 3 4 5 6 7 8 9 0 100 200 300 400 500 600 700 800 900</td>
</tr>
</tbody>
</table>
47. Continued

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>a</th>
<th>b</th>
</tr>
</thead>
<tbody>
<tr>
<td>7) You put your penis in her anus/butt (anal sex).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IF NONE, SKIP TO ITEM (10).</td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<td>IF ONE PARTNER: Did you use a condom every time for anal sex, even if it broke, tore, or slipped?</td>
<td></td>
<td></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></td>
<td></td>
</tr>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td>10) You used your tongue to touch or lick her anus/butt (&quot;rimming&quot;).</td>
<td></td>
<td></td>
</tr>
<tr>
<td>11) You used your tongue to touch or lick her genitals (vagina, clitoris).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

48. Have you had any sort of sexual activity with a man since your last visit?
- No
- Yes
  SKIP TO Q 51

49. 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?
50. 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>1) You put your penis in his mouth. IF NONE, SKIP TO ITEM (4).</td>
<td>ORIN1_41 NOINM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>2) Thinking of the times you put your penis in his mouth, with how many men did you use a condom every time, even if it broke, tore, or slipped?</td>
<td>COIN1_41 NCOIM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<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></td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3) With how many men did you ejaculate/cum in their mouths when you did not use a condom (or when a condom failed)?</td>
<td>OEJM1_41 NOEJM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>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>IF MULTIPLE PARTNERS:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4) You put your penis in his anus/butt. IF NONE, SKIP TO ITEM (7).</td>
<td>ANIN1_41 NAINM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</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>NCAIM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>If #5b &lt; #4 then read:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>Of the men you did not use a condom with,</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>5b.1) Were any of these men HIV positive?</td>
<td>HPAIM_41 HNAIM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>5b.2) Were any of these men HIV negative?</td>
<td>HUAIM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>If 5b.1 or 5b.2 = Don’t Know/Not Sure, skip to 6b.</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>5b.3) Were you unsure of the HIV status of any of these men?</td>
<td>NCAIN1_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF ONE PARTNER:</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>If 5a = No,</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>HIVSTAT1_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</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>AEJM1_41 NAEJM_41</td>
<td>0 0 0 0 0 0 0 0 0 0</td>
</tr>
<tr>
<td>IF ONE PARTNER:</td>
<td></td>
<td>0 0 0 0 0 0 0 0 0 0</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>Question</th>
<th>Column</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. IF NONE, SKIP TO ITEM (10).</td>
<td>a) ORRC1_41 NORCM_41</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>b) NCORM_41</td>
<td></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>b) CORR1_41</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>b) NOEM_41</td>
<td></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>b) OREM1_41</td>
<td></td>
</tr>
<tr>
<td>10) He put his penis in your anus/butt. IF NONE, SKIP TO ITEM (13).</td>
<td>a) ANRC1_41 NARIM_41</td>
<td></td>
</tr>
<tr>
<td>11a.) 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>b) NCARM_41</td>
<td></td>
</tr>
<tr>
<td>If #11b &lt; #10 then read: Of the men who did not use a condom,</td>
<td>b) HPARM_41 HNARIM_41</td>
<td></td>
</tr>
<tr>
<td>11b.1) Were any of these men HIV positive?</td>
<td>b) HPARM_41</td>
<td></td>
</tr>
<tr>
<td>11b.2) Were any of these men HIV negative?</td>
<td>b) HNARIM_41</td>
<td></td>
</tr>
<tr>
<td>If 11b.1 or 11b.2 = Don’t Know/Not Sure, skip to 12b. 11b.3) Were you unsure of the HIV status of any of these men?</td>
<td>b) HUARIM_41</td>
<td></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>b) CANR1_41</td>
<td></td>
</tr>
<tr>
<td>If 11a = No, 11a.1) What was the HIV status of your partner when he did not use a condom?</td>
<td>b) HIVSTAT2_41</td>
<td></td>
</tr>
<tr>
<td>IF MULTIPLE PARTNERS:</td>
<td>b)</td>
<td></td>
</tr>
<tr>
<td>12a.) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</td>
<td>b) NAREM_41</td>
<td></td>
</tr>
<tr>
<td>IF ONE PARTNER: 12a.) Did ejaculate/cum go into your anus/butt when he did not use a condom (or when a condom failed)?</td>
<td>b) AREM1_41</td>
<td></td>
</tr>
</tbody>
</table>
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?

<table>
<thead>
<tr>
<th>KIND OF ACTIVITY</th>
<th>NO</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>13) You used your tongue to touch or lick his anus/butt (“rimming”).</td>
<td>RIM1_41</td>
<td>NRMIM_41</td>
</tr>
</tbody>
</table>

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

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

PART1_41

50.15) 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?

- o No
- o Yes

PARTM_41

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

- o No
- o Yes

MPANA_41

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

- o Negative
- o Positive
- o I don’t know

MPHIV_41

50.18) 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

METIN_41
METPY_41
METAD_41
METBAR_41
METBH_41
METOP_41
METIP_41
METDR_41
METOT_41
METNO_41
51. 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>Drug Code</th>
<th>Code 1</th>
<th>Code 2</th>
<th>Code 3</th>
<th>Code 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pot, Marijuana or Hash</td>
<td>HASHV_41</td>
<td>HASHF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>“Poppers” like nitrite inhalants (amyl, butyl or isopropyl nitrites)</td>
<td>POPPV_41</td>
<td>POPPF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Crack or cocaine that you smoke</td>
<td>CRACV_41</td>
<td>CRACF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other forms of cocaine</td>
<td>OCOKV_41</td>
<td>OCOKF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speed, Meth or Ice</td>
<td>UPPRV_41</td>
<td>UPPRF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>HEROV_41</td>
<td>HEROF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speedball (heroin and cocaine together)</td>
<td>SPEBV_41</td>
<td>SPEBF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ecstasy, XTC, X or MDMA</td>
<td>MDAV_41</td>
<td>MDAF_41</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other kinds of street/club drugs</td>
<td>STMDV_41</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Specify:
- STMD1_41 ST1DF_41
- STMD2_41 ST2DF_41
- STMD3_41 ST3DF_41
- STMD4_41 ST4DF_41
- STMD5_41 ST5DF_41
- STMD6_41 ST6DF_41
<table>
<thead>
<tr>
<th>Question</th>
<th>Options</th>
<th>Skip to Q</th>
</tr>
</thead>
<tbody>
<tr>
<td>52.A. [Since your last visit in (MONTH)] have you injected recreational</td>
<td>drugs (skin popped, shot up with a needle)?</td>
<td>58</td>
</tr>
<tr>
<td>55.A. [Since your last visit in (MONTH)] have you shared water to</td>
<td>rinse your needles with anyone?</td>
<td>No 58</td>
</tr>
<tr>
<td>inject recreational drugs in a shooting gallery?</td>
<td>yes 58</td>
<td></td>
</tr>
<tr>
<td>B. Were any of these times that you injected recreational drugs in a</td>
<td>shooting gallery?</td>
<td>41</td>
</tr>
<tr>
<td>B. How many times?</td>
<td>no 41</td>
<td></td>
</tr>
<tr>
<td>C. Do you currently inject drugs?</td>
<td>yes 41</td>
<td></td>
</tr>
<tr>
<td>D. Thinking about the period when you injected how many times did you</td>
<td>inject [DRUG] per month?</td>
<td>41</td>
</tr>
<tr>
<td>Speedball (cocaine and heroin together)</td>
<td>0, 10, 20, 30, 40, 50, 60, 70, 80, 90</td>
<td>58</td>
</tr>
<tr>
<td>Cocaine by itself</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9</td>
<td>58</td>
</tr>
<tr>
<td>Heroin by itself</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9</td>
<td>58</td>
</tr>
<tr>
<td>Speed by itself</td>
<td>0, 1, 2, 3, 4, 5, 6, 7, 8, 9</td>
<td>58</td>
</tr>
<tr>
<td>53. [Since your last visit in (MONTH)] have you shared a needle or</td>
<td>works with anyone?</td>
<td>58</td>
</tr>
<tr>
<td>56. [Since your last visit in (MONTH)] how often did you clean your</td>
<td>works with bleach?</td>
<td>11</td>
</tr>
<tr>
<td>57.A. [Since your last visit in (MONTH)] have you participated in a</td>
<td>no 11</td>
<td></td>
</tr>
<tr>
<td>58. [Since your last visit in (MONTH)] have you been in a drug</td>
<td>yes 11</td>
<td></td>
</tr>
<tr>
<td>Interviewer Instructions:</td>
<td>Thank the participant.</td>
<td></td>
</tr>
<tr>
<td>End record time on page 20.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>