1. What is the name of your primary care provider in this clinic?


PRE-EXISTING CONDITIONS

2. Has your doctor ever told you that you have any of the following?  
   a. Anemia or "low blood"
   b. Angina or Coronary Heart Disease
   c. Heart Attack or Myocardial Infarction
   d. Congestive Heart Failure, also called weak heart or fluid on the lungs
   e. Dementia or "Alzheimer's"
   f. Diabetes or high blood sugar or "sugar"
   g. Liver Disease or a bad liver or Cirrhosis
   h. Hepatitis C
   i. Chronic Hepatitis B
   j. High cholesterol, lipids, or triglycerides
   k. Hypertension or high blood pressure
   l. Pancreatitis
   m. Bad nerves in your feet causing pain and numbness (neuropathy)
   n. Bad circulation in your legs or feet
   o. Chronic lung disease (emphysema, asthma, chronic bronchitis or chronic obstructive lung disease)
   p. Kidney Failure (or bad kidneys)
   q. Stroke or "mini" stroke (Transient Ischemic Attack)
   r. Pneumonia
   s. Shingles
   t. TB or Tuberculosis
   u. Depression
   v. Post-Traumatic Stress Disorder (PTSD)
   w. Schizophrenia (hearing voices or seeing things that others don't)
   x. Any kind of Cancer (please list below)
3. How much do you weigh? (in pounds) (Fill in one oval)

<table>
<thead>
<tr>
<th>Option</th>
<th>Weight Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>0 90 lbs. or less</td>
<td>0 131 - 140 lbs.</td>
</tr>
<tr>
<td>0 91 - 100 lbs.</td>
<td>0 141 - 150 lbs.</td>
</tr>
<tr>
<td>0 101 - 110 lbs.</td>
<td>0 151 - 160 lbs.</td>
</tr>
<tr>
<td>0 111 - 120 lbs.</td>
<td>0 161 - 170 lbs.</td>
</tr>
<tr>
<td>0 121 - 130 lbs.</td>
<td>0 171 - 180 lbs.</td>
</tr>
<tr>
<td>0 181 - 190 lbs.</td>
<td>0 231 - 240 lbs.</td>
</tr>
<tr>
<td>0 241 - 250 lbs.</td>
<td>0 281 - 290 lbs.</td>
</tr>
<tr>
<td>0 291 - 300 lbs.</td>
<td>0 301 - 310 lbs.</td>
</tr>
<tr>
<td>0 311 - 320 lbs.</td>
<td>0 311 - 320 lbs.</td>
</tr>
<tr>
<td>0 261 - 270 lbs.</td>
<td>0 321 lbs. or more</td>
</tr>
</tbody>
</table>

4. How often do you engage in regular activities (e.g. brisk walking, jogging, bicycling, etc.) long enough to work up a sweat?

- 0 NEVER
- 0 LESS THAN ONCE A WEEK
- 0 1 - 2 TIMES A WEEK
- 0 3 - 4 TIMES A WEEK
- 0 5 OR MORE TIMES A WEEK

5. Do you now smoke cigarettes (i.e. within the last week)?

- 0 YES
- 0 NO

6. Do you have a father or brother who had a heart attack or angina before age 55?

- 0 YES
- 0 NO

7. Do you have a mother or sister who had a heart attack or angina before age 65?

- 0 YES
- 0 NO
8. Have any of your relatives had what you would call a significant drinking problem (one that did or should have led to treatment)?
   0 YES
   0 NO
   (If yes, fill in the ovals next to relatives that apply)
   __________

   | Mother's side: 0 Mother 0 Grandmother 0 Grandfather 0 Aunts 0 Uncles |
   | Father's side: 0 Aunts 0 Father 0 Grandmother 0 Grandfather 0 Uncles |
   | Siblings       0 Sister 0 Brother                           |

9. In the past 4 weeks have you been concerned about having enough food for you or your family?
   0 YES
   0 NO

10. In the past 4 weeks, have you been without a permanent address that you call home?
   0 YES
   0 NO

11. In the past 4 weeks, have you stayed one or more nights in the following: (mark all that apply)
   0 ON THE STREET, AT A PARK, AN ABANDONED BUILDING, OR IN A CAR
   0 A SHELTER OR AN EMERGENCY SHELTER
   0 A SUBSIDIZED APARTMENT OR HOME AWAITING PERMANENT HOUSING
   0 WITH FAMILY OR FRIENDS TEMPORARILY UNTIL YOU FIND YOUR OWN PLACE
   0 NONE OF THE ABOVE

12. Have you ever stayed one or more nights in the following: (mark all that apply)
   0 ON THE STREET, AT A PARK, AN ABANDONED BUILDING, OR IN A CAR
   0 A SHELTER OR AN EMERGENCY SHELTER
   0 A SUBSIDIZED APARTMENT OR HOME AWAITING PERMANENT HOUSING
   0 WITH FAMILY OR FRIENDS TEMPORARILY UNTIL YOU FIND YOUR OWN PLACE
   0 NONE OF THE ABOVE
NOTE: For answering these questions, one "drink" is equal to 12 ounces of beer (1 can), or 4 ounces of wine (1 glass), or 1 ounce of liquor (1 shot).

13. In the last 12 months have you ever had a drink containing alcohol?
   0 YES (If yes, please continue)
   0 NO, NEVER (If no, skip to question #28)

14. How often do you have a drink containing alcohol?
   0 NEVER
   0 MONTHLY OR LESS
   0 TWO TO FOUR TIMES A MONTH
   0 TWO TO THREE TIMES A WEEK
   0 FOUR OR MORE TIMES A WEEK

15. How many drinks containing alcohol do you have on a typical day when you are drinking?
   0 1 OR 2
   0 3 OR 4
   0 5 OR 6
   0 7 TO 9
   0 10 OR MORE

16. How often do you have six or more drinks on one occasion?
   0 NEVER
   0 LESS THAN MONTHLY
   0 MONTHLY
   0 WEEKLY
   0 DAILY OR ALMOST DAILY
17. How often during the last 12 months have you found that you were not able to stop drinking once you had started?
   - NEVER
   - LESS THAN MONTHLY
   - MONTHLY
   - WEEKLY
   - DAILY OR ALMOST DAILY

18. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?
   - NEVER
   - LESS THAN MONTHLY
   - MONTHLY
   - WEEKLY
   - DAILY OR ALMOST DAILY

19. How often during the last 12 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?
   - NEVER
   - LESS THAN MONTHLY
   - MONTHLY
   - WEEKLY
   - DAILY OR ALMOST DAILY

20. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?
   - NEVER
   - LESS THAN MONTHLY
   - MONTHLY
   - WEEKLY
   - DAILY OR ALMOST DAILY
21. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?

0 NEVER
0 LESS THAN MONTHLY
0 MONTHLY
0 WEEKLY
0 DAILY OR ALMOST DAILY

22. Have you or someone been injured as a result of your drinking?

0 NEVER
0 YES, BUT NOT IN THE LAST YEAR
0 YES, DURING THE LAST YEAR

23. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?

0 NO
0 YES, BUT NOT IN THE LAST YEAR
0 YES, DURING THE LAST YEAR

24. How many drinks of alcohol does it take for you to begin to feel a "buzz" or high?

0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 >8 0 HAVE NEVER FELT A "BUZZ" OR HIGH

25. How many drinks of alcohol does it take for you to begin to lose control or feel drunk?

0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 8 0 9 0 >10 0 HAVE NEVER FELT THIS WAY
26. Here are a number of events that drinkers sometimes experience. Read each one carefully and please fill in the oval that indicates if this ever happened to you and how often it has happened to you during the past 3 months.

**DURING THE PAST 3 MONTHS, ABOUT HOW OFTEN HAS THIS HAPPENED TO YOU?**

<table>
<thead>
<tr>
<th>Event</th>
<th>Never</th>
<th>Once or a Few Times</th>
<th>Once or Twice a Week</th>
<th>Daily or Almost Daily</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. I have been unhappy because of my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Because of my drinking, I have not eaten properly.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. I have failed to do what is expected of me because of my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. I have felt guilty or ashamed because of my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. I have taken foolish risks when I have been drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. When drinking, I have done impulsive things that I regret later.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. My physical health has been harmed by my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. I have had money problems because of my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. My physical appearance has been harmed by my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. My family has been hurt by my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. A friendship or close relationship has been damaged by my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. My drinking has gotten in the way of my growth as a person.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>m. My drinking has damaged my social life, popularity, or reputation.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>n. I have spent too much or lost a lot of money because of my drinking.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>o. I have had an accident while drinking or intoxicated.</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
27. Have you had any of the following symptoms in the last 12 months?
Mark all that apply. (Please note this question refers only to the last 12 months.)

- 0 THE SHAKES
- 0 BEING UNABLE TO SLEEP
- 0 FEELING VERY NERVOUS OR RESTLESS
- 0 SWEATING
- 0 YOUR HEART BEATING FAST
- 0 SEEING OR HEARING THINGS THAT OTHERS COULD NOT SEE OR HEAR
- 0 HEADACHES
- 0 NAUSEA OR VOMITING
- 0 WEAKNESS
- 0 FITS OR SEIZURES

28. For each of the following drugs, please fill in the oval that best indicates how often in the past 12 months you used each drug.

<table>
<thead>
<tr>
<th>Drug Description</th>
<th>Have Never Tried</th>
<th>No Use in the Last Year</th>
<th>Less Than Once a Month</th>
<th>1 - 3 Times a Month</th>
<th>1 - 3 Times a Week</th>
<th>4 - 6 Times a Week</th>
<th>Everyday</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Marijuana or Hashish</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Cocaine or Crack</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, b-am)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Heroin</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Prescription benzodiazepines (Valium, Depakote, Ativan)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Other (please specify):</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
29. In the past 12 months, did your use of drugs ever interfere with your work at school, or a job, or at home?

0 YES  (If YES, please answer #30a)
0 NO   (If NO, please skip to #33)
0 DID NOT USE DRUGS

30. How often in the past 12 months did drugs interfere with your work at school, or a job, or at home?

0 ONCE OR TWICE
0 BETWEEN 3 AND 5 TIMES
0 BETWEEN 6 AND 10 TIMES
0 BETWEEN 11 AND 20 TIMES
0 MORE THAN 20 TIMES

31. In the past 12 months, were you ever under the influence of a drug in a situation where you could get hurt -like when driving a car or boat, using knives, guns or machinery, or anything else?

0 YES
0 NO

32. In the past 12 months, have you ever used a needle to inject any drug? DO NOT include anything you took under a doctor's orders.

0 YES
0 NO
The next questions are about your sexual behavior. We recognize the following questions may be personal. We ask that you complete them to the best of your ability. By sex we mean oral, vaginal, or anal sex, but NOT masturbation. When we talk about condoms, we mean both male as well as female condoms.

33. During the past 12 months, have you had sex?
   0 YES
   0 NO

34. Thinking back about the last time you had sex, did you or your partner use a condom?
   0 YES
   0 NO

35. During the past 12 months, have you had sex with only males, only females, or with both males and females?
   0 ONLY MALES
   0 ONLY FEMALES
   0 BOTH MALES AND FEMALES

36. How many sexual partners have you had in the past 12 months?
   0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 >8

37. In the past 12 months, have you ever exchanged money or drugs for sex?
   0 NO
   0 YES, AND I HAD PROTECTED SEX
   0 YES, AND I HAD UNPROTECTED SEX
   0 YES, AND I HAD BOTH PROTECTED AND UNPROTECTED SEX
   0 I PREFER NOT TO ANSWER THIS QUESTION

38. In the past 12 months, have you had sex with anyone that you did not know ahead of time (anonymous/casual sex)?
   0 YES
   0 NO
   0 I PREFER NOT TO ANSWER THIS QUESTION
39. Have you been tested for HIV?
   0 NO, I HAVE NEVER BEEN TESTED
   0 YES, AND MY LAST TEST WAS NEGATIVE
   0 YES, AND MY LAST TEST WAS POSITIVE
   0 YES, AND MY LAST TEST WAS INDETERMINATE
   0 YES, I WAS TESTED BUT HAVE NOT RETURNED FOR MY RESULTS
   0 I PREFER NOT TO ANSWER THIS QUESTION

40. In the past 12 months have you been diagnosed with any of the following sexually transmitted diseases (STDs)? Answer as many as apply.

   I was diagnosed with:

   0 CHLAMYDIA
   0 GONORRHEA
   0 SYPHILIS
   0 TRICHOMONAS
   0 CHANCROID
   0 LICE / SCABIES
   0 HERPES
   0 GENITAL WARTS
   0 NON-SPECIFIC URETHRITIS / NON-GONOCOCCAL URETHRITIS
   0 MONONUCLEOSIS ("MONO")
   0 ANOTHER SEXUALLY TRANSMITTED DISEASE
   0 I WAS NOT DIAGNOSED WITH ANY OF THESE INFECTIONS
   0 I PREFER NOT TO ANSWER THIS QUESTION
41. In the past 12 months, how often have you practiced safer sex (used a male or female condom)?
   0 EVERY TIME I HAVE SEX WITH EVERY PARTNER
   0 WITH EACH PARTNER, I SOMETIMES PRACTICE SAFER SEX, BUT NOT ALWAYS
   0 WITH SOME PARTNERS I ALWAYS PRACTICE SAFER SEX, AND WITH OTHER PARTNERS I DO NOT
   0 I AM SEXUALLY ACTIVE BUT I NEVER PRACTICE SAFER SEX
   0 I DO NOT HAVE TO PRACTICE SAFER SEX SINCE I AM NOT AT RISK FOR HIV OR OTHER STDs
   0 I AM NOT SEXUALLY ACTIVE
   0 I PREFER NOT TO ANSWER THIS QUESTION

42. Have you ever had sex with a person who had HIV or another STD?
   0 NO, NOT THAT I KNOW OF
   0 NO, I AM CERTAIN THAT EVERYONE I HAD SEX WITH HAS NOT HAD AN STD OR HIV
   0 YES, I HAD SEX WITH A PERSON DIAGNOSED WITH HIV
   0 YES, I HAD SEX WITH A PERSON DIAGNOSED WITH AN STD OTHER THAN HIV
   0 I PREFER NOT TO ANSWER THIS QUESTION

43. If you ever had sex with a person who you knew or suspected had HIV or another STD, did you:
   0 PRACTICE SAFER SEX EVERY TIME
   0 PRACTICE SAFER SEX SOME OF THE TIME, BUT NOT ALWAYS
   0 NEVER PRACTICE SAFER SEX
   0 I NEVER HAD SEX WITH A PERSON I KNEW OR SUSPECTED HAD HIV OR ANOTHER STD
   0 I PREFER NOT TO ANSWER THIS QUESTION

44. Thinking back about the last time you had sex, were you using alcohol or drugs?
   0 YES
   0 NO

45. In the past 12 months, have you used alcohol to help you feel more comfortable with a sexual partner?
   0 YES
   0 NO

46. In the past 12 months, have you done more sexually than you had planned because you were drinking?
   0 YES
   0 NO
47. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking?

0 YES
0 NO

SKIP if you have not had a drink in the past 12 months. (Go on to question #49)

48. In this section, we would like to know about the effects that drinking alcohol has on you. Here is a list of some effects that many people feel after drinking alcohol. Please fill in the oval that describes how much alcohol affects you in each way.

Does alcohol have this effect on you?

<table>
<thead>
<tr>
<th>Effect</th>
<th>Not at all</th>
<th>A little</th>
<th>Some</th>
<th>Very much</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Feel less self conscious</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Feel closer to a sexual partner</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Am a better lover</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Am more sexually responsive</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Am less nervous about sex</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Am more self confident</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Become more sexually forward</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Feel less shy</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Get horny (want sex)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Enjoy sex more</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Have sex with people that I wouldn't have sex</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. Am more likely to do something sexually that is</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>m. Lose my inhibitions</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
49. Thinking back about the last time you had sex, were you under the influence of drugs?
   0 YES
   0 NO  If no, SKIP to question #52

50. In the last 12 months, have you used drugs to help you feel more comfortable with a sexual partner?
   0 YES
   0 NO

51. Which of the following helped you feel more comfortable? (You may choose more than 1).

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana or Hashish</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cocaine or Crack</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prescription benzodiazepines (Valium, Deastat, Ativan)</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
52. In the **past 12 months**, have you done more sexually than you had planned because you were using drugs?

0 YES
0 NO  **If no, SKIP to question #54**

53. Which of the following caused you to do more sexually than you had planned (you may choose more than 1).

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Marijuana or Hashish</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Cocaine or Crack</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Stimulants (amphetamines, uppers, speed, crank, crystal meth, bamm)</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Heroin</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Prescription Opioids (Morphine, Codeine, Vicodin, Percocet, Oxycontin)</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Prescription benzodiazepines (Valium, Deastat, Ativan)</strong></td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Other (please specify):</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

54. In the **past 12 months**, have you had unprotected sex (not used a condom) because you were using drugs?

0 YES
0 NO  **If no, SKIP to question #56**

0 MIGHT HAVE
55. Which of the following caused you to have unprotected sex (you may choose more than 1).

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Marijuana or Hashish</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Cocaine or Crack</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Stimulants</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(amphetamines, uppers, speed, crank, crystal meth, bam)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Heroin</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Prescription Opioids</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Morphine, Codeine, Vicodin, Percocet, Oxycontin,)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prescription benzodiazepines</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>(Valium, Deastat, Ativan)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other (please specify):</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

56. Do you have health insurance outside the VA?  
0 YES  
0 NO  
(If yes, please answer below)

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Do you have private health insurance?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Do you have Medicaid?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Do you have Medicare?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Do you have other forms of public health insurance?</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>
57. During the last 3 months, were you seen in any of the following for these reasons. If yes, please fill in the oval. If no, SKIP to question #58.

<table>
<thead>
<tr>
<th></th>
<th>VA</th>
<th>OUTSIDE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. In a hospital for medical problems</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. In a hospital for psychological or emotional problems</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. In a hospital for detoxification</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. In an outpatient program for alcohol treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. In an outpatient program for other drug treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. In a residential program for alcohol treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. In a residential program for other drug treatment</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. In a halfway house</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. In a holding unit; a place where someone can stay while they wait for a bed to open up in a program. (generally no services are provided in the holding unit).</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

58. During the last 3 months, did you do any of the following? If yes, please fill in the oval. If no, SKIP to question #60.

<table>
<thead>
<tr>
<th></th>
<th>VA</th>
<th>OUTSIDE CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Go to an Emergency Room for medical care</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Fill your prescription medication</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Call for Telephone Advice</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

59. If you received care outside the VA, what were your reasons? (please fill in the ovals).

- LOCATION
- INSURANCE
- DISSATISFACTION WITH VA CARE
- UNABLE TO GET APPOINTMENT WITH VA CARE
- RELATIONSHIP WITH PROVIDER OUTSIDE THE VA
- OTHER REASONS
60. During the last 3 months, did you go to meetings of Alcoholics Anonymous (AA),
self-help, mutual-help, or another 12-step program?

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. For alcohol?</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. For drugs?</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

61. During the last 3 months, did you receive counseling for alcohol problems from:

- 0 PRIEST/MINISTER/RABBI OR OTHER CLERGY
- 0 AN EMPLOYEE ASSISTANCE PROGRAM
- 0 ALCOHOLICS ANONYMOUS
- 0 EMERGENCY ROOM
- 0 OTHER
- 0 DID NOT RECEIVE COUNSELING

62. During the last 3 months, have you taken any medications prescribed by a physician:

<table>
<thead>
<tr>
<th></th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. To prevent you from drinking.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. To help you detoxify/come off alcohol.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. To help you stabilize or change your use of drugs other than alcohol.</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. For your psychological or emotional problems.</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

Many people have many pills to take at different times during the day and find it hard to always remember their pills. Please tell us what you are doing. Don't worry about telling us that you don't take all your doses. We need to know what is really happening, not what you think we "want to hear." Please fill in the oval for the one response that best describes how you take your medications.

If you do not take medications regularly, please SKIP to question #70

63. In the past 12 months, when you take your prescription medications, how often do you take all the medications you're supposed to?

- 0 NEVER
- 0 SOME OF THE TIME
- 0 ABOUT HALF OF THE TIME
- 0 MOST OF THE TIME
- 0 ALL OF THE TIME
64. In the past 12 months, is there a particular medication that you are more likely to miss than the others?

0 YES If yes, do any of these reasons explain why?
0 NO

<table>
<thead>
<tr>
<th>Reason</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>I have to take it at an inconvenient time</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I have to worry about taking it with or without food</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I don't like the side effects</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>The pill is hard to swallow or tastes bad</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

65. Do you ever stop taking your medications for a while or take a "drug holiday" that was not recommended by your doctor?

0 NEVER
0 LESS THAN MONTHLY
0 MONTHLY
0 WEEKLY
0 MORE THAN WEEKLY

If you do stop taking your medications for a while,

A. How often is this something you do on purpose?

0 NEVER
0 SOME OF THE TIME
0 ABOUT HALF OF THE TIME
0 MOST OF THE TIME
0 ALL OF THE TIME
B. How long does it last for?

0 2 DAYS
0 3 OR 4 DAYS
0 BETWEEN 5 AND 7 DAYS
0 BETWEEN 1 WEEK AND 1 MONTH
0 MORE THAN 1 MONTH

C. Does it tend to occur around the following times?

WEEKENDS:  
0 NEVER
0 SOME OF THE TIME
0 ABOUT HALF OF THE TIME
0 MOST OF THE TIME
0 ALL OF THE TIME

VACATIONS:  
0 NEVER
0 SOME OF THE TIME
0 ABOUT HALF OF THE TIME
0 MOST OF THE TIME
0 ALL OF THE TIME

PAYDAYS (WHEN YOU RECEIVE EMPLOYER OR GOVERNMENT CHECKS):

0 NEVER
0 SOME OF THE TIME
0 ABOUT HALF OF THE TIME
0 MOST OF THE TIME
0 ALL OF THE TIME

66. Did you miss any of your prescription medications last weekend--(last Saturday or Sunday)?

0 YES
0 NO

67. When was the last time you missed any of your prescription medications?

0 WITHIN THE PAST WEEK
0 1-2 WEEKS AGO
0 2-4 WEEKS AGO
0 1-3 MONTHS AGO
0 OVER 3 MONTHS AGO
0 NEVER MISSED
68. During the **past 4 days**, on how many days have you missed taking any of your doses?  
0 NONE  
0 ONE DAY  
0 TWO DAYS  
0 THREE DAYS  
0 FOUR DAYS  

69. The following questions ask about symptoms you might have had during the past four weeks. Please fill in the oval of the one response that best describes this symptom.

<table>
<thead>
<tr>
<th>Symptom Description</th>
<th>I DO NOT HAVE THIS SYMPTOM</th>
<th>I HAVE THIS SYMPTOM AND...</th>
<th>IT DOESN'T BOTHER ME</th>
<th>IT BOTHERS ME A LITTLE</th>
<th>IT BOTHERS ME</th>
<th>IT BOTHERS ME A LOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Fatigue or loss of energy?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Fevers, chills, or sweats?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Feeling dizzy or light headed?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. Pain, numbness, or tingling in the hands or feet?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. Trouble remembering?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Nausea or vomiting?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Diarrhea or loose bowel movements?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Felt sad, down, or depressed?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Felt nervous or anxious?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Difficulty falling or staying asleep?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Skin problems, such as rash, dryness, or itching?</td>
<td>0</td>
<td></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>I HAVE THIS SYMPTOM AND...</td>
<td>I DO NOT HAVE THIS SYMPTOM</td>
<td>IT DOESN'T BOTHER ME</td>
<td>IT BOTHERS ME A LITTLE</td>
<td>IT BOTHERS ME</td>
<td>IT BOTHERS ME A LOT</td>
<td></td>
</tr>
<tr>
<td>---------------------------</td>
<td>-----------------------------</td>
<td>----------------------</td>
<td>------------------------</td>
<td>---------------</td>
<td>---------------------</td>
<td></td>
</tr>
<tr>
<td>l. Cough or trouble catching your breath?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>m. Headache?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>n. Loss of appetite or change in the taste of food?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>o. Bloating, pain, or gas in your stomach?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>p. Muscle aches or joint pain?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>q. Problems with having sex, such as loss of interest or lack of satisfaction?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>r. Changes in the way your body looks, such as fat deposits or weight gain?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>s. Problems with weight loss or wasting?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>t. Hair loss or changes in the way your hair looks?</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
</tbody>
</table>

70. Do you think your symptoms are caused by drugs you take to treat medical conditions?

0 YES
0 NO
0 UNSURE

71. Do you think your symptoms are caused by drinking alcohol?

0 YES
0 NO
0 UNSURE
72. During the **past year**, how often did you attend religious services?

- 0 NEVER
- 0 LESS THAN TWICE A YEAR
- 0 SEVERAL TIMES A YEAR
- 0 ABOUT ONCE A MONTH
- 0 TWO TO THREE TIMES A MONTH
- 0 EVERY WEEK
- 0 SEVERAL TIMES A WEEK
- 0 EVERYDAY

73. How frequently do you pray?

- 0 NEVER
- 0 LESS THAN TWICE A YEAR
- 0 SEVERAL TIMES A YEAR
- 0 ABOUT ONCE A MONTH
- 0 TWO TO THREE TIMES A MONTH
- 0 EVERY WEEK
- 0 SEVERAL TIMES A WEEK
- 0 EVERYDAY

74. How important is religion to you?

- 0 VERY IMPORTANT
- 0 IMPORTANT
- 0 SOMEWHAT IMPORTANT
- 0 NOT VERY IMPORTANT
- 0 NOT AT ALL IMPORTANT

75. In the last 12 months, when you have problems or difficulties in your life, how often do you seek spiritual comfort and support?

- 0 ALMOST ALWAYS
- 0 OFTEN
- 0 SOMETIMES
- 0 RARELY
- 0 NEVER
76. Over the last 2 weeks, how often have you been bothered by any of the following problems?

<table>
<thead>
<tr>
<th></th>
<th>NOT AT ALL</th>
<th>SEVERAL DAYS</th>
<th>MORE THAN HALF THE DAYS</th>
<th>NEARLY EVERY DAY</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>a. Little interest or pleasure in doing things</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>b. Feeling down, depressed, or hopeless</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>c. Trouble falling/staying asleep, sleeping too much</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>d. Feeling tired or having little energy</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>e. Poor appetite or overeating</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>g. Trouble concentrating on things, such as reading the newspaper or watching television</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>h. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>i. Thoughts that you would be better off dead or of hurting yourself in some way</strong></td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

77. If you checked off any problem listed above, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

0 NOT DIFFICULT AT ALL
0 SOMEWHAT DIFFICULT
0 VERY DIFFICULT
0 EXTREMELY DIFFICULT
78. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by filling in the oval under the appropriate response after each statement.

<table>
<thead>
<tr>
<th></th>
<th>YES, I CAN DO THIS</th>
<th>YES, BUT ONLY SLOWLY</th>
<th>NO, I CANNOT DO THIS</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Can you do heavy work at home, like scrubbing floors, lifting or moving heavy furniture?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>c. Can you do light work around the house like dusting or washing dishes?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball or rowing a boat?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>e. If you want to, can you run a short distance?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>f. Can you walk uphill or upstairs?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>g. Can you walk a block or more?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>h. Can you walk around inside the house?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>i. Can you walk to a table for meals?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>j. Can you dress yourself?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>k. Can you eat without help?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>l. Can you use the bathroom without help?</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

These questions ask for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer each question by filling in the oval. If you are unsure about how to answer, please try your best.

79. In general, would you say your health is:

   0 EXCELLENT
   0 VERY GOOD
   0 GOOD
   0 FAIR
   0 POOR
The following items are about activities you might do during a typical day. Does your health now limit you in these activities? If so, how much?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Yes, Limited a Lot</th>
<th>Yes, Limited a Little</th>
<th>No, Not Limited at All</th>
</tr>
</thead>
<tbody>
<tr>
<td>80. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>81. Climbing several flights of stairs</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

During the past 4 weeks, have you had any of the following problems with your work or other daily activities as a result of your physical health?

82. Accomplished less than you would like
    0 YES
    0 NO

83. Were limited in the kind of work or other activities
    0 YES
    0 NO

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

84. Accomplished less than you would like
    0 YES
    0 NO

85. Didn't do work or other activities as carefully as usual
    0 YES
    0 NO
86. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

0 NOT AT ALL
0 A LITTLE BIT
0 MODERATELY
0 QUITE A BIT
0 EXTREMELY

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling. How much of the time during the past 4 weeks -

|--------------------------|-----------------|------------------|------------------------|-----------------|----------------------|-----------------|

87. Have you felt downhearted and blue? 0 0 0 0 0 0

88. Did you have a lot of energy? 0 0 0 0 0 0

89. Have you felt calm and peaceful? 0 0 0 0 0 0

90. During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

0 ALL OF THE TIME
0 MOST OF THE TIME
0 SOME OF THE TIME
0 A LITTLE OF THE TIME
0 NONE OF THE TIME
91. In the past 12 months, what is your annual household income?

0 LESS THAN $6,000
0 $6,000 TO $11,999
0 $12,000 TO $24,999
0 $25,000 TO $49,999
0 OVER $50,000

92. In the past 12 months, how many persons live in your household (including yourself)?

93. Are you currently...(mark all that apply)

0 EMPLOYED FOR WAGES
0 SELF - EMPLOYED
0 LOOKING FOR WORK AND UNEMPLOYED FOR MORE THAN ONE YEAR
0 LOOKING FOR WORK AND UNEMPLOYED FOR LESS THAN ONE YEAR
0 HOMEMAKER
0 STUDENT
0 RETIRED
0 UNABLE TO WORK

94. What is your current marital status?

0 MARRIED
0 DIVORCED
0 SEPARATED
0 WIDOWED
0 NEVER MARRIED
0 LIVING WITH PARTNER

Thank you for completing our questionnaire.
Please return this to the Survey coordinator who gave it to you.