3907478817

VACS PATIENT QUESTIONNAIRE - ID
FOLLOW-UP 3

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FOR ADMINISTRATIVE USE ONLY. TO BE COMPLETED BY STUDY COORDINATOR.

Date of Visit: __ __ / __ __ / __ __ __ __ **Study ID** __ __ __ __ __ __

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?

	YES	NO
a. Anemia or "low blood"	0	0
b. Angina or Coronary Heart Disease	0	0
c. Heart Attack or Myocardial Infarction	0	0
d. Congestive Heart Failure, also called weak heart or fluid on the lungs	0	0
e. Dementia or "Alzheimer's"	0	0
f. Diabetes or high blood sugar or "sugar"	0	0
g. Liver Disease or a bad liver or Cirrhosis	0	0
h. Hepatitis C	0	0
i. Chronic Hepatitis B	0	0
j. High cholesterol, lipids, or triglycerides	0	0
k. Hypertension or high blood pressure	0	0
l. Pancreatitis	0	0
m. Bad nerves in your feet causing pain and numbness (neuropathy)	0	0
n. Bad circulation in your legs or feet	0	0
o. Chronic lung disease (emphysema, asthma, chronic bronchitis or chronic obstructive lung disease)	0	0
p. Kidney Failure (or bad kidneys)	0	0
q. Stroke or "mini" stroke (Transient Ischemic Attack)	0	0
r. Pneumonia	0	0
s. Shingles	0	0
t. TB or Tuberculosis	0	0
u. Depression	0	0
v. Post-Traumatic Stress Disorder (PTSD)	0	0
w. Schizophrenia (hearing voices or seeing things that others don't)	0	0
x. Any kind of Cancer (please list below)	0	0

9	1	0	0	0	0

Study ID ☐☐☐☐☐☐

3. Has your doctor ever told you that you have any of the following?

	YES	NO
a. Pneumocystis Pneumonia or PCP	O	O
b. Kaposi's Sarcoma or KS	O	O
c. Lymphoma (non Hodgkins)	O	O
d. Atypical Mycobacterium or MAI or MAC	O	O
e. Cryptosporidiosis	O	O
f. Coccidioidomycosis	O	O
g. Histoplasmosis	O	O
h. Isosporiasis	O	O
i. Toxoplasmosis (in your head or brain)	O	O
j. Salmonella in your blood	O	O
k. CMV in your eye (retinitis), elsewhere in your lungs, colon, stomach, or esophagus.	O	O
l. Severe weight loss due to your HIV infection (Wasting)	O	O
m. Problems thinking due to your HIV infection (HIV Dementia)	O	O
n. Candida or fungus in your mouth or throat (Thrush)	O	O
o. Cryptococcus	O	O
p. Herpes simplex	O	O
q. Herpes zoster	O	O

HEALTH HABITS

4. How much do you weigh? (in pounds) (Fill in one circle)

O 90 lbs. or less	O 131 - 140 lbs.	O 181 - 190 lbs.	O 231 - 240 lbs.	O 281 - 290 lbs.
O 91 - 100 lbs.	O 141 - 150 lbs.	O 191 - 200 lbs.	O 241 - 250 lbs.	O 291 - 300 lbs.
O 101 - 110 lbs.	O 151 - 160 lbs.	O 201 - 210 lbs.	O 251 - 260 lbs.	O 301 - 310 lbs.
O 111 - 120 lbs.	O 161 - 170 lbs.	O 211 - 220 lbs.	O 261 - 270 lbs.	O 311 - 320 lbs
O 121 - 130 lbs.	O 171 - 180 lbs.	O 221 - 230 lbs	O 271 - 280 lbs.	O 321 lbs. or more

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

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

6. Have you smoked at least 100 cigarettes in your ENTIRE LIFE?
   - O YES
   - O NO (If No, skip to # 9)

7A. Do you now smoke cigarettes (as of 1 month ago)?
   - O YES
   - O NO

7B. How old were you when you FIRST started to smoke fairly REGULARLY?

   Age in years

7C. On average of the ENTIRE TIME you smoked, how many cigarettes did you smoke per day?

   Cigarettes per day

7D. How many cigarettes do you smoke per day NOW?

   Cigarettes per day

7E. During the PAST 12 MONTHS, have you stopped smoking for more than one day because you were trying to quit?
   - O YES
   - O NO
   - O Does not apply

7F. If you have stopped smoking cigarettes in the last 12 months, did you stop because of health problems?
   - O YES
   - O NO
   - O Does not apply

7G. If you stopped smoking cigarettes completely for at least 12 months, how old were you when you STOPPED?

   Age in years

8. Please look at the scale below. Each statement represents where various people are in thinking about quitting smoking. Fill in the circle next to the statement that best indicates where you are now
   - O HAVE ALREADY QUIT
   - O THINKING ABOUT QUITTING
   - O NOT READY TO QUIT
   - O NOT SURE
   - O NOT THINKING ABOUT QUITTING

9. These are questions about how often your lung/respiratory problems have affected you over the past 12 months. Please fill in one circle for each question.

	ALMOST EVERY DAY	SEVERAL DAYS A WEEK	A FEW DAYS A MONTH	ONLY WITH LUNG/RESPIRATORY INFECTIONS	NOT AT ALL
9A. Over the last year, I have coughed:	0	0	0	0	0
9B. Over the last year, I have brought up phlegm (sputum):	0	0	0	0	0
9C. Over the last year, I have had shortness of breath:	0	0	0	0	0
9D. Over the last year, I have had episodes of wheezing:	0	0	0	0	0

10A. Have you received counseling concerning exercise or weight loss?

0 YES (If Yes, please answer #10B)

0 NO (If No, please skip to #10C)

10B. If yes, who counseled you on weight loss? Check all that apply.

0 NURSE
0 DIETICIAN
0 DOCTOR
0 OTHER HEALTH PROFESSIONAL
0 PHYSICIAN'S ASSISTANT

10C. IN THE PAST 12 MONTHS, would you generally describe yourself as:

0 UNDERWEIGHT
0 SOMEWHAT OVERWEIGHT
0 ABOUT THE RIGHT WEIGHT
0 EXTREMELY OVERWEIGHT

NOTE: For answering these questions, one "drink" is equal to 12 ounces of beer (1can), or 4 ounces of wine (1 glass), or 1 ounce of liquor (1 shot).

11A. Have you EVER had a drink of alcohol?

0 YES

0 NO (If No, skip to question #25)

11B. Have you EVER had problems with alcohol?

0 YES

0 NO (If No, skip to question #11D)

11C. Did you stop drinking because of these problems?

- 0 YES
- 0 NO

11D. How old were you when you first started to drink?

Age in years

11E. If you have stopped drinking completely, how old were you when you stopped?

Age in years

12. In the last 12 months have you had a drink containing alcohol?

- 0 YES
- 0 NO (If No, skip to #23A)

13. 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

14. 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

15. 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

16. How often during the last 12 months have you found that you were not able to stop drinking once you had started?

- 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 failed to do what was normally expected from you because of drinking?

 () NEVER
 () LESS THAN MONTHLY
 () MONTHLY
 () WEEKLY
 () DAILY OR ALMOST DAILY

18. 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

19. 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

20. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?

 () NEVER
 () LESS THAN MONTHLY
 () MONTHLY
 () WEEKLY
 () DAILY OR ALMOST DAILY

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

 () NEVER
 () YES, BUT NOT IN THE LAST YEAR
 () YES, DURING THE LAST YEAR

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

 () NO
 () YES, BUT NOT IN THE LAST YEAR
 () YES, DURING THE LAST YEAR

For each statement below, fill in one circle to indicate how you might agree or disagree with each statement.

	NO STRONGLY DISAGREE	NO DISAGREE	UNDECIDED OR UNSURE	YES AGREE	YES STRONGLY AGREE
23A. I really want to make changes in my drinking:	0	0	0	0	0
23B. Sometimes I wonder if I'm an alcoholic:	0	0	0	0	0
23C. If I don't change my drinking soon, my problems are going to get worse:	0	0	0	0	0
23D. I have already started making some changes in my drinking:	0	0	0	0	0
23E. I was drinking too much at one time, but I've managed to change my drinking:	0	0	0	0	0
23F. Sometimes I wonder if my drinking is hurting other people:	0	0	0	0	0
23G. I am a problem drinker:	0	0	0	0	0
23H. I'm not just thinking about changing my drinking, I'm already doing something about it:	0	0	0	0	0
23I. I have already changed my drinking, and I am looking for ways to keep from slipping back to my old pattern:	0	0	0	0	0
23J. I have serious problems with drinking:	0	0	0	0	0
23K. Sometimes I wonder if I am in control of my drinking:	0	0	0	0	0
23L. My drinking is causing a lot of harm:	0	0	0	0	0
23M. I am actively doing things now to cut down or stop drinking:	0	0	0	0	0
23N. I want help to keep from going back to the drinking problems that I had before:	0	0	0	0	0
23O. I know that I have a drinking problem:	0	0	0	0	0
23P. There are times when I wonder if I drink too much:	0	0	0	0	0
23Q. I am an alcoholic:	0	0	0	0	0
23R. I am working hard to change my drinking:	0	0	0	0	0
23S. I have made some changes in my drinking, and I want some help to keep from going back to the way I used to drink:	0	0	0	0	0

24. Look at the scale below. Each statement represents where various people are in thinking about changing their drinking. Please fill in the circle next to the statement that best indicates where you are now.

- 0 HAVE ALREADY CHANGED
- 0 NOT SURE
- 0 THINKING ABOUT CHANGING
- 0 NOT THINKING ABOUT CHANGING
- 0 NOT READY

25. Have you ever used prescription drugs only for the experience or feeling they caused?

- 0 YES
- 0 NO (If NO, please skip to #28)

26. Have you ever, even once, used one of the medications listed below that was NOT prescribed for you or that you took only for the experience or feeling it caused?
(These questions are about the use of pain relievers. We are NOT interested in your use of "over the counter" pain medications such as aspirin, Tylenol or Advil.)

Please check all that apply.

	EVER USED	USED IN THE PAST 12 MONTHS
Buprenorphine	0	0
Codeine	0	0
Darvocet	0	0
Darvon	0	0
Demerol	0	0
Dilaudid	0	0
Fioricet	0	0
Fiorinal	0	0
Hydrocodone	0	0
Methadone	0	0
Morphine	0	0
Oxycontin	0	0
Percocet	0	0
Percodan	0	0
Propoxyphene	0	0
Talwin	0	0
Tylenol with codeine	0	0
Tylox	0	0
Ultram	0	0
Vicodin	0	0
Other	0	0

please specify ____________________

27. Now think only about the past 12 months. On average, how many days each week in the past 12 months did you use any prescription pain reliever that was not prescribed for you or that you took only for the experience or feeling that it caused?

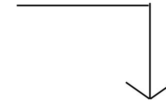
Average number of days per week ☐

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

			IN THE LAST 12 MONTHS				
	HAVE NEVER TRIED	NO USE IN THE LAST YEAR	LESS THAN ONCE A MONTH	1 - 3 TIMES A MONTH	1 - 3 TIMES A WEEK	4 - 6 TIMES A WEEK	EVERY DAY
a. Marijuana or Hashish	O	O	O	O	O	O	O
b. Cocaine or Crack	O	O	O	O	O	O	O
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	O	O	O	O	O	O	O
d. Heroin	O	O	O	O	O	O	O
e. Prescription benzodiazepines (Valium, Deastat, Ativan)	O	O	O	O	O	O	O
f. Other (please specify): ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐							

29. In the past 12 months, did your use of drugs ever interfere with your work at school, or a job, or at home?

O YES (If YES, please answer #29a)
O NO (If NO, please skip to #33)
O DID NOT USE DRUGS (Please skip to #33)



29a. How often in the past 12 months did drugs interfere with your work at school, or a job, or at home?

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

30. 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 or guns or machinery, or anything else?

O YES
O NO

31. 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 order.
   - 0 YES
   - 0 NO

32. Look at the scale below. Each statement below represents where various people are in thinking about changing their drug use/habits. Please fill in the circle next to the statement that best indicates where you are now.
   - 0 HAVE ALREADY CHANGED
   - 0 THINKING ABOUT CHANGING
   - 0 NOT READY
   - 0 NOT SURE
   - 0 NOT THINKING ABOUT CHANGING

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 (If NO, skip to question #51)

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 last 12 months?

   0 0 0 1 0 2 0 3 0 4 0 5 0 6 0 7 0 >8

36A. Of these people, how many of them were new partners, that is, people you had oral, anal, or vaginal sex with for the first or only time in the last 12 months?

   0 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 used any prescription drug to improve sexual performance, such as Viagra, Cialis or Levitra?
   - 0 YES
   - 0 NO

38. Thinking back about the last time you had sex, had you been drinking alcohol?
   - 0 YES
   - 0 NO

39. In the past 12 months, have you used alcohol to help you feel more comfortable with a sexual partner?

    0 YES

    0 NO

40. In the past 12 months, have you done more sexually than you had planned because you were drinking alcohol?

    0 YES

    0 NO

41. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking alcohol?

    0 YES

    0 NO

42. Thinking about the last time you had sex, were you using drugs?

    0 YES

    0 NO

43. In the past 12 months, have you used drugs to help you feel more comfortable with a sexual partner?

    0 YES

    0 NO

44. In the past 12 months, have you done more sexually than you had planned because you were using drugs?

    0 YES

    0 NO

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

    0 YES

    0 NO

46. In the past 12 months, have you been diagnosed with any of the following sexually transmitted diseases (STDs)? Please fill in all those that apply.

    0 chlamydia

    0 gonorrhea

    0 syphilis

    0 trichomonas

    0 chancroid

    0 lice or scabies

    0 herpes

    0 non-specific urethritis/ non-gonococcal urethritis

    0 genital warts

    0 another sexually transmitted disease

    0 None of these infections

    0 I prefer not to answer this question

47. In the past 12 months, have you told your sexual partners that you were HIV positive?

- I TOLD EVERY PARTNER
- I TOLD SOME PARTNERS, BUT NOT ALL OF THEM
- I DID NOT TELL ANY OF THEM

48. During the past 12 months, on average, how often have you had sex?

- DID NOT HAVE SEX
- ABOUT ONCE A MONTH OR LESS
- A FEW TIMES A MONTH
- A FEW TIMES A WEEK
- EVERY DAY

49. During the past 12 months when you had sex, how often did you use a condom?

- DID NOT HAVE SEX
- NEVER
- SOMETIMES
- USUALLY
- ALWAYS

50. During the past 12 months, did you ever, even once, have unprotected vaginal or anal sex (sex without a condom) with any of the following types of partners?

	Yes (unprotected sex at least once)	No (always used a condom)
a. A main partner (spouse or long-term lover)	O	O
b. Any other partner (date, fling, someone you just met)	O	O
c. Any partner who was HIV positive	O	O
d. Any partner who was HIV negative	O	O
e. Any partner whose HIV status was unknown	O	O

51. In the past 12 months, has your primary health care provider asked you anything about your sexual behavior?

- YES
- NO

52. Please indicate whether you AGREE or DISAGREE or DON'T KNOW with each statement below:

	AGREE	DISAGREE	DON'T KNOW
a. Condoms do not always prevent HIV infection	0	0	0
b. I do not like using condoms	0	0	0
c. I sometimes did not use a condom because I was drinking or using drugs	0	0	0
d. I sometimes did not use a condom because I did not have one	0	0	0
e. My sexual partners do not like me to use condoms	0	0	0
f. I don't need to use condoms with my main partner	0	0	0
g. HIV infection is not as serious as it used to be	0	0	0
h. A person with HIV cannot transmit HIV if his/her viral load is undetectable	0	0	0
i. I am not at risk for getting HIV or sexually transmitted diseases	0	0	0
j. I am not at risk of transmitting HIV or STDs	0	0	0

53. 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 AWAITING PERMANENT HOUSING
0 NONE OF THE ABOVE

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

	YES	NO
a. Do you have private health insurance?	0	0
b. Do you have Medicaid?	0	0
c. Do you have Medicare?	0	0
d. Do you have other forms of public health insurance?	0	0

55. During the last 3 months, were you seen in any of the following for these reasons.

	VA	OUTSIDE CARE	DOES NOT APPLY
a. In a hospital for medical problems	0	0	0
b. In a hospital for psychological or emotional problems	0	0	0
c. In a hospital for detoxification	0	0	0
d. In an outpatient program for alcohol treatment	0	0	0
e. In an outpatient program for other drug treatment	0	0	0
f. In a residential program for alcohol treatment	0	0	0
g. In a residential program for other drug treatment	0	0	0
h. In a halfway house	0	0	0
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).	0	0	0

56. During the last 3 months, did you do any of the following.

	VA	OUTSIDE CARE	DOES NOT APPLY
a. Go to an Emergency Room for medical care	0	0	0
b. Fill your prescription medication	0	0	0
c. Receive your HIV care	0	0	0
d. Fill your HIV prescription medication	0	0	0
e. Call for Telephone Advice	0	0	0

57. If you received care outside the VA, what were your reasons? (Mark all that aplly)

0 UNABLE TO GET APPOINTMENT WITH VA CARE
0 RELATIONSHIP WITH PROVIDER OUTSIDE THE VA
0 DISSATISFACTION WITH VA CARE
0 DID NOT RECEIVE CARE OUTSIDE THE VA
0 LOCATION
0 INSURANCE
0 OTHER REASONS

58. IN THE LAST 12 MONTHS where did you get your HIV care?

0 VA PROVIDER
0 NON-VA PROVIDER

59. IN THE LAST 12 MONTHS, where did you get your general medical care?

0 VA PROVIDER
0 DOES NOT APPLY
0 NON-VA PROVIDER

60. Where did you get your HIV medications?

0 NO MEDICATION IN THE LAST 12 MONTHS
0 AT THE NON-VA PHARMACY ONLY
0 AT THE VA PHARMACY ONLY
0 BOTH VA AND NON-VA PHARMACIES

61. During the last 3 months, did you go to meetings of Alcoholics Anonymous (AA), self-help, mutual-help, or another 12-step program?

	YES	NO
a. For alcohol?	0	0
b. For drugs?	0	0
c. For HIV related problems?	0	0

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

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

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

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

64. Do you now take medications to treat your HIV?

0 YES
0 NO (If NO, skip to question #68)

64A. Most HIV medications need to be taken on a schedule, such as "2 times a day," or "3 times a day," or "every 8 hours." How closely did you follow your specific schedule over the last four days?

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

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

O YES
O NO

66. When was the last time you missed any of your HIV medications?

O WITHIN THE PAST WEEK
O 1-2 WEEKS AGO
O 2-4 WEEKS AGO
O 1-3 MONTHS AGO
O OVER 3 MONTHS AGO
O NEVER MISSED

67. During the past 4 days, on how many days have you missed taking any of your doses?

O NONE
O ONE DAY
O TWO DAYS
O THREE DAYS
O FOUR DAYS

68. Have you ever taken antiretroviral medications (medicine to treat your HIV)?

O YES
O NO (If NO, skip to question #72)

69. Have you ever been prescribed antiretroviral medications outside the VA?

O YES
O NO (If NO, skip to question #72)

70. Were you prescribed antiretroviral medications outside the VA prior to coming to the VA for HIV care?

O YES
O NO (If NO, skip to question #72)

70A. If yes, for how long?

O LESS THAN 3 MONTHS
O 3 TO 6 MONTHS
O 7 TO 12 MONTHS
O 13 TO 24 MONTHS
O 25 TO 35 MONTHS
O 36 MONTHS OR MORE

71. Since coming to the VA for HIV care, have you been prescribed antiretroviral medications outside the VA?

O YES
O NO (If NO, skip to question #72)

71A. If yes, please indicate why you were prescribed these medications outside the VA. (Please mark all that apply)

O FOR RESEARCH STUDY
O TO FILL IN MISSING DOSES WHILE YOU WERE TRAVELING
O FOR ONGOING CARE AT A NON-VA FACILITY

Questions 72a-u are from the *Beck Anxiety Inventory*®

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

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

74A. Do you think your symptoms from question #73 are caused by the drugs you take to treat your HIV infection?

0 YES
0 I DO NOT TAKE MEDICATIONS FOR HIV
0 NO

74B. Do you think your symptoms from question #73 are caused by drinking alcohol?

0 YES
0 NO

74C: Do you think your symptoms from question # 73 are caused by the drugs that you take to treat your other medical conditions (other than HIV?)

0 YES
0 NO

75. On a scale of 0 to 10, where 0 means no pain and 10 equals the worst possible pain, what is your current pain level? (If pain equals 0 (zero) please skip to #77)

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

No Pain ... Worst Possible Pain

76A. In general, how much does your pain problem interfere with your day to day activities? (Please mark one)

0 0   0 1   0 2   0 3   0 4   0 5   0 6

No Interference ... Extreme Interference

76B. Since the time you developed a pain problem how much has your pain changed your ability to work? (Please mark one)

0 0   0 1   0 2   0 3   0 4   0 5   0 6

No Change ... Extreme Change

76C. How much has your pain changed the amount of satisfaction or enjoyment you get from participating in social and recreational activities? (Please mark one)

0 0   0 1   0 2   0 3   0 4   0 5   0 6

No Change ... Extreme Change

76D. How much has your pain changed your ability to participate in recreational and other social activities? (Please mark one)

0 0   0 1   0 2   0 3   0 4   0 5   0 6

No Change ... Extreme Change

76E. How much has your pain changed the amount of satisfaction you get from family-related activities? (Please mark one)

0 0   0 1   0 2   0 3   0 4   0 5   0 6

No Change ... Extreme Change

76F. How much has your pain changed your marriage and other family relationships? (Please mark one)

O 0 O 1 O 2 O 3 O 4 O 5 O 6

No Change — Extreme Change

76G. How much has your pain changed the amount of satisfaction or enjoyment you get from work? (Please mark one)

O 0 O 1 O 2 O 3 O 4 O 5 O 6

No Change — Extreme Change

76H. How much has your pain changed your ability to do household chores? (Please mark one)

O 0 O 1 O 2 O 3 O 4 O 5 O 6

No Change — Extreme Change

76I. How much has your pain changed your friendships with people other than your family? (Please mark one)

O 0 O 1 O 2 O 3 O 4 O 5 O 6

No Change — Extreme Change

77. Over the last 2 weeks, how often have you been bothered by any of the following problems?

	NOT AT ALL	**SEVERAL DAYS**	**MORE THAN HALF THE DAYS**	**NEARLY EVERY DAY**
a. Little interest or pleasure in doing things	O	O	O	O
b. Feeling down, depressed, or hopeless	O	O	O	O
c. Trouble falling/staying asleep, sleeping too much	O	O	O	O
d. Feeling tired or having little energy	O	O	O	O
e. Poor appetite or overeating	O	O	O	O
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	O	O	O	O
g. Trouble concentrating on things, such as reading the newspaper or watching television	O	O	O	O
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	O	O	O	O
i. Thoughts that you would be better off dead or of hurting yourself in some way	O	O	O	O

78. 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 VERY DIFFICULT
0 SOMEWHAT DIFFICULT
0 EXTREMELY DIFFICULT

79. These questions are about any physical limitations you might have. For these activities, please indicate which response best describes you by filling in the circle under the appropriate response after each statement.

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

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 circle. If you are unsure about how to answer, please try your best.

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

0 EXCELLENT
0 FAIR
0 VERY GOOD
0 POOR
0 GOOD

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?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
81. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
82. Climbing several flights of stairs	0	0	0

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?

83. Accomplished less than you would like

0 YES

0 NO

84. 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)?

85. Accomplished less than you would like

0 YES

0 NO

86. Didn't do work or other activities as carefully as usual

0 YES

0 NO

87. 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 -

	ALL OF THE TIME	MOST OF THE TIME	A GOOD BIT OF THE TIME	SOME OF THE TIME	A LITTLE OF THE TIME	NONE OF THE TIME
88. Have you felt downhearted and blue?	0	0	0	0	0	0
89. Did you have a lot of energy?	0	0	0	0	0	0
90. Have you felt calm and peaceful?	0	0	0	0	0	0

91. During the past 4 weeks, how much of the time have 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

92. Do you have an email address?

0 YES
0 NO

93A. Do you have access to the internet?

0 YES
0 NO

93B. If yes, where do you have access to the internet?

0 HOME
0 WORK
0 LIBRARY
0 OTHER

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