VACS PATIENT QUESTIONNAIRE - ID
FOLLOW-UP 4

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?

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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	0	0

3. Has your doctor ever told you that you have any of the following?	YES	NO
a. Pneumocystis Pneumonia or PCP	0	0
b. Kaposi's Sarcoma or KS	0	0
c. Lymphoma (non Hodgkins)	0	0
d. Atypical Mycobacterium or MAI or MAC	0	0
e. Cryptosporidiosis	0	0
f. Coccidioidomycosis	0	0
g. Histoplasmosis	0	0
h. Isosporiasis	0	0
i. Toxoplasmosis (in your head or brain)	0	0
j. Salmonella in your blood	0	0
k. CMV in your eye (retinitis), elsewhere in your lungs, colon, stomach, or esophagus.	0	0
l. Severe weight loss due to your HIV infection (Wasting)	0	0
m. Problems thinking due to your HIV infection (HIV Dementia)	0	0
n. Candida or fungus in your mouth or throat (Thrush)	0	0
o. Cryptococcus	0	0
p. Herpes simplex	0	0
q. Herpes zoster	0	0

4. Has your doctor ever told you that you have any of the following lung or breathing conditions?	YES	NO
a. Asthma	0	0
b. Emphysema	0	0
c. Chronic bronchitis	0	0
d. Chronic Obstructive Pulmonary Disease (COPD)	0	0
e. IPF (idiopathic pulmonary fibrosis) or lung fibrosis	0	0
f. Sarcoidosis	0	0
g. Pulmonary hypertension or high blood pressure in the lungs	0	0
h. A blood clot in your lungs or a pulmonary embolism	0	0
i. Sleep apnea	0	0

5. Have you ever been diagnosed with any of the following types of cancer?	YES	NO
a. Skin: Basal Cell	0	0
b. Skin: Melanoma	0	0
c. Kaposi's Sarcoma	0	0
d. Lymphoma: Non-Hodgkins	0	0
e. Lymphoma: Hodgkins	0	0
f. Lung	0	0
g. Mouth or Throat	0	0
h. Stomach	0	0
i. Colon	0	0
j. Liver	0	0
k. Rectal	0	0
l. Anal	0	0
m. Bladder	0	0
n. Testicular	0	0
o. Prostate	0	0
p. Breast	0	0
q. Cervical	0	0
r. Leukemia	0	0
s. Multiple Myeloma	0	0

HEALTH HABITS

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

0 90 lbs. or less	0 131 - 140 lbs.	0 181 - 190 lbs.	0 231 - 240 lbs.	0 281 - 290 lbs.
0 91 - 100 lbs.	0 141 - 150 lbs.	0 191 - 200 lbs.	0 241 - 250 lbs.	0 291 - 300 lbs.
0 101 - 110 lbs.	0 151 - 160 lbs.	0 201 - 210 lbs.	0 251 - 260 lbs.	0 301 - 310 lbs.
0 111 - 120 lbs.	0 161 - 170 lbs.	0 211 - 220 lbs.	0 261 - 270 lbs.	0 311 - 320 lbs
0 121 - 130 lbs.	0 171 - 180 lbs.	0 221 - 230 lbs	0 271 - 280 lbs.	0 321 lbs. or more

7. 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 1 - 2 TIMES A WEEK	0 5 OR MORE TIMES A WEEK
0 LESS THAN ONCE A WEEK	0 3 - 4 TIMES A WEEK	

8. Have you smoked at least 100 cigarettes (5 packs) in your ENTIRE LIFE?

   0 YES 0 NO (If No, skip to # 14)

9. Do you now smoke cigarettes (as of 1 month ago)?

   0 YES 0 NO

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

    Age in years ☐☐

11. How long has it been since you last smoked cigarettes?

    0 LESS THAN ONE MONTH
    0 1-5 MONTHS
    0 6-11 MONTHS
    0 1-5 YEARS
    0 MORE THAN 5 YEARS
    0 STILL SMOKING

12. How many cigarettes do you smoke per day NOW?

    Cigarettes per day ☐☐☐

13. 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.

    0 HAVE ALREADY QUIT
    0 THINKING ABOUT QUITTING
    0 NOT READY TO QUIT
    0 NOT SURE
    0 NOT THINKING ABOUT QUITTING

14. 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
A. Over the last year, I have coughed:	0	0	0	0	0
B. Over the last year, I have brought up phlegm (sputum):	0	0	0	0	0
C. Over the last year, I have had shortness of breath:	0	0	0	0	0
D. Over the last year, I have had episodes of wheezing:	0	0	0	0	0

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).

15. Have you EVER had a drink of alcohol?

0 YES
0 NO (If No, skip to question #32)

16. Have you EVER had problems with alcohol?

0 YES
0 NO (If No, skip to question #18)

17. Did you stop drinking because of these problems?

0 YES
0 NO

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

0 YES
0 NO (If No, skip to #31)

19. 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

20. 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

21. 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

22. 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

23. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?

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

24. 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?

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

25. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?

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

26. 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

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

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

28. 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

29. 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 Greater than 10 0 Have never felt this way

30. 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 Greater than 8 0 Have never felt a buzz or high

31. 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 THINKING ABOUT CHANGING
0 NOT READY
0 NOT SURE
0 NOT THINKING ABOUT CHANGING

PRESCRIPTION DRUG USE

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

0 YES

0 NO (If NO, please skip to #35)

33. 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.

	ANY LIFETIME USE	HAVE USED IN PAST 12 MONTHS
a. Buprenorphine	0	0
b. Codeine	0	0
c. Darvocet	0	0
d. Darvon	0	0
e. Demerol	0	0
f. Dilaudid	0	0
g Fentanyl	0	0
h. Fioricet	0	0
i. Fiorinal	0	0
j. Hydrocodone	0	0
k. Methadone	0	0
l. Morphine	0	0
m. Oxycontin	0	0
n. Percocet	0	0
o. Percodan	0	0
p. Propoxyphene	0	0
q. Talwin	0	0
r. Tylenol with codeine	0	0
s. Tylox	0	0
t. Ultram	0	0
u. Vicodin	0	0
v. Other	0	0

34. 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 ☐

OTHER DRUG USE

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

	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
		IN THE LAST 12 MONTHS					
a. Marijuana or Hashish	0	0	0	0	0	0	0
b. Cocaine or Crack	0	0	0	0	0	0	0
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	0	0	0	0	0	0	0
d. Heroin	0	0	0	0	0	0	0
e. Prescription painkillers (such as Oxycontin, Vicodin, Percocet)	0	0	0	0	0	0	0
f. Prescription benzodiazepines (Valium,Deastat, Ativan)	0	0	0	0	0	0	0
g. Other	0	0	0	0	0	0	0

36. In the <u>past 12 months</u>, did your use of drugs ever interfere with your work at school, or a job, or at home?

0 YES (If YES, please answer #37)
0 NO (If NO, please skip to #38)
0 DID NOT USE DRUGS (Please skip to #41)

37. How often in the <u>past 12 months</u> 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

38. In the <u>past 12 months</u>, 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?

0 YES
0 NO

39. 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

40. 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.

41. During the past 12 months, have you had sex?

0 YES
0 NO (If NO, skip to question #60)

42. Thinking back about the last time you had sex, did you or your partner use a condom?

0 YES
0 NO

43. 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

44. 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 or more

45. 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 or more

46. 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

47. Thinking back about the last time you had sex, had you been drinking alcohol?

0 YES
0 NO

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

0 YES 0 NO

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

0 YES 0 NO

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

0 YES 0 NO

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

0 YES 0 NO

52. In the past 12 months, have you had unprotected sex (not used a condom) with someone you know has multiple partners?

0 YES 0 NO 0 Unsure

53. In the past 12 months, have you had unprotected sex (not used a condom) with someone who injects drugs?

0 YES 0 NO 0 Unsure

54. In the past 12 months have you paid for sex?

0 YES 0 NO

55. In the past 12 months have you <u>been</u> paid for sex ?

0 YES 0 NO

56. In the past 12 months have you been diagnosed with a sexually transmitted disease?

0 YES 0 NO

57. In the past 12 months have you had unprotected sex (not used a condom) with someone who had been diagnosed with a sexually transmitted disease?

0 YES 0 NO 0 Unsure

58. In the past 12 months have you had unprotected sex (not used a condom) with someone you know who has the HIV virus?

0 YES 0 NO 0 Unsure

59. 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)	0	0
b. Any other partner (date, fling, someone you just met)	0	0
c. Any partner who was HIV positive	0	0
d. Any partner who was HIV negative	0	0
e. Any partner whose HIV status was unknown	0	0

HEALTH CARE

60. 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 detoxification	0	0	0
b. In an outpatient program for alcohol treatment	0	0	0
c. In an outpatient program for drug treatment	0	0	0
d. In a residential program for alcohol treatment	0	0	0
e. In a residential program for other drug treatment	0	0	0
f. In a halfway house	0	0	0

61. 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

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

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

63. 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

64. During the last 3 months, did you receive counseling for alcohol problems from: (Mark all that apply)

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

65. In the past 12 months did you make any visits to medical offices, health care clinics, or hospitals for a lung or breathing problem?

0 NO
0 YES, WITHIN THE VA
0 YES, OUTSIDE THE VA
0 YES, BOTH WITHIN AND OUTSIDE THE VA

66. Please indicate the extent to which you agree or disagree with each statement of the following statements:

	STRONGLY AGREE	AGREE	NEITHER AGREE NOR DISAGREE	DISAGREE	STRONGLY DISAGREE
a. I think HIV causes AIDS.	0	0	0	0	0
b. A lot of information about AIDS is being held back from the general public.	0	0	0	0	0
c. The medicines used to treat HIV are saving lives.	0	0	0	0	0
d. There is a cure for AIDS, but it is being withheld from the poor.	0	0	0	0	0

67. 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

68. 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	0	0	0	0
b. Feeling down, depressed, or hopeless	0	0	0	0
c. Trouble falling/staying asleep, sleeping too much	0	0	0	0
d. Feeling tired or having little energy	0	0	0	0
e. Poor appetite or overeating	0	0	0	0
f. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	0	0	0
g. Trouble concentrating on things, such as reading the newspaper or watching television	0	0	0	0
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	0	0	0	0
i. Thoughts that you would be better off dead or of hurting yourself in some way	0	0	0	0

69. 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

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.

70. 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?

	YES, LIMITED A LOT	YES, LIMITED A LITTLE	NO, NOT LIMITED AT ALL
71. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
72. 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?

73. Accomplished less than you would like

0 YES 0 NO

74. 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)?

75. Accomplished less than you would like

0 YES 0 NO

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

0 YES 0 NO

77. 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
78. Have you felt downhearted and blue?	0	0	0	0	0	0
79. Did you have a lot of energy?	0	0	0	0	0	0
80. Have you felt calm and peaceful?	0	0	0	0	0	0

81. 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

The next set of questions asks about your experience with the doctor that provides a majority of your medical care. Thinking about the doctor who provides a majority of your medical care:

	COMPLETELY	MOSTLY	SOMEWHAT	A LITTLE	NOT AT ALL
82. How much do you trust your doctor to offer you high quality medical care?	0	0	0	0	0
83. How much do you trust your doctor to know all about the very best treatments and care for HIV?	0	0	0	0	0
84. How much do you trust your doctor to give you enough information about your condition to make decisions?	0	0	0	0	0
85. How much do you trust your doctor to keep personal information private?	0	0	0	0	0
86. How much do you trust your doctor to respond to things you tell him or her in a caring and non-judgmental way?	0	0	0	0	0
87. How much do you trust your doctor to offer you high quality medical care regardless of VA rules or cost?	0	0	0	0	0
88. How much do you trust your doctor to put your needs ahead of scientific research goals?	0	0	0	0	0

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