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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?

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PRE-EXISTING CONDITIONS

2. Has your doctor ever told you that you have any of the following? YES NO

Table with 3 columns: Condition (a-x), YES, NO. Rows include: a. Anemia or "low blood", b. Angina or Coronary Heart Disease, c. Heart Attack or Myocardial Infarction, d. Congestive Heart Failure, e. Dementia or "Alzheimer's", f. Diabetes or high blood 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.

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3. Has your doctor ever told you that you have any of the following?	<u>YES</u>	<u>NO</u>
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 <u>ever</u> told you that you have any of the following lung or breathing conditions?	<u>YES</u>	<u>NO</u>
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

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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

6. Has your doctor ever told you that you have any of the following heart or cardiac conditions?

**YES**      **NO**

a. Intermittent claudication or pain in legs from blockage of the arteries	0	0
b. Deep vein thrombosis (DVT) blood clot in legs	0	0
c. A blood clot in your lungs or a pulmonary embolism	0	0

7. Have you have had any of the following procedures in or out of the hospital?

**YES**      **NO**

a. Angioplasty, PTCA, coronary artery bypass graft for CABG or any procedure to open up arteries in your heart	0	0
b. Cardiac catheterization or coronary angiography	0	0
c. Any procedure to open up arteries in your legs	0	0

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8. Did your mother, ever have a heart attack or myocardial infarction?

YES (if yes, answer #8a)

NO (skip to #9)

DON'T KNOW (skip to #9)

8a How old was your mother when the first heart attack occurred?

LESS THAN 55

55 - 64

65 OR OLDER

DON'T KNOW AGE

9. Did your father, ever have a heart attack or myocardial infarction?

YES (if yes, answer #9a)

NO (skip to #10)

DON'T KNOW (skip to #10)

9a. How old was your father when the first heart attack occurred?

LESS THAN 55

55 - 64

65 OR OLDER

DON'T KNOW AGE

10. Did your mother, father, full-blooded sisters, full-blooded brothers, daughters, or sons ever have a stroke?

YES (if yes, answer #10a)

NO (skip to #11)

DON'T KNOW (skip to #11)

10a. How many of these relatives had a stroke?

1

2

3

4 OR MORE

### **HEALTH HABITS**

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

90 lbs. or less

131 - 140 lbs.

181 - 190 lbs.

231 - 240 lbs.

281 - 290 lbs.

91 - 100 lbs.

141 - 150 lbs.

191 - 200 lbs.

241 - 250 lbs.

291 - 300 lbs.

101 - 110 lbs.

151 - 160 lbs.

201 - 210 lbs.

251 - 260 lbs.

301 - 310 lbs.

111 - 120 lbs.

161 - 170 lbs.

211 - 220 lbs.

261 - 270 lbs.

311 - 320 lbs.

121 - 130 lbs.

171 - 180 lbs.

221 - 230 lbs.

271 - 280 lbs.

321 lbs. or more

12. How much did you weigh at age 20? (in pounds) (Fill in one circle)

90 lbs. or less

131 - 140 lbs.

181 - 190 lbs.

231 - 240 lbs.

281 - 290 lbs.

91 - 100 lbs.

141 - 150 lbs.

191 - 200 lbs.

241 - 250 lbs.

291 - 300 lbs.

101 - 110 lbs.

151 - 160 lbs.

201 - 210 lbs.

251 - 260 lbs.

301 - 310 lbs.

111 - 120 lbs.

161 - 170 lbs.

211 - 220 lbs.

261 - 270 lbs.

311 - 320 lbs.

121 - 130 lbs.

171 - 180 lbs.

221 - 230 lbs.

271 - 280 lbs.

321 lbs. or more

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

NEVER

1 - 2 TIMES A WEEK

5 OR MORE TIMES A WEEK

LESS THAN ONCE A WEEK

3 - 4 TIMES A WEEK

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14. Have you smoked at least 100 cigarettes (5 packs) in your ENTIRE LIFE?  
 YES       NO (If No, skip to # 20)

15. Do you now smoke cigarettes (as of 1 month ago)?  
 YES       NO

16. How old were you when you FIRST started to smoke fairly REGULARLY?  
 Age in years     

17. How long has it been since you last smoked cigarettes?  
 LESS THAN ONE MONTH       1-5 YEARS  
 1-5 MONTHS       MORE THAN 5 YEARS  
 6-11 MONTHS       STILL SMOKING

18. How many cigarettes do you smoke per day NOW?  
 Cigarettes per day     

19. 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.

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

**20. 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.**

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

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**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).**

21. Have you EVER had a drink of alcohol?

- YES  
 NO (If No, skip to question #38)

22. Have you EVER had problems with alcohol?

- YES  
 NO (If No, skip to question #24)

23. Did you stop drinking because of these problems?

- YES  
 NO

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

- YES  
 NO (If No, skip to #37)

25. How often do you have a drink containing alcohol?

- NEVER  TWO TO THREE TIMES A WEEK  
 MONTHLY OR LESS  FOUR OR MORE TIMES A WEEK  
 TWO TO FOUR TIMES A MONTH

26. How many drinks containing alcohol do you have on a typical day when you are drinking?

- 1 OR 2  7 TO 9  
 3 OR 4  10 OR MORE  
 5 OR 6

27. How often do you have six or more drinks on one occasion?

- NEVER  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY

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

- NEVER  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY

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29. How often during the last 12 months have you failed to do what was normally expected from you because of drinking?
- NEVER  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY
30. 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  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY
31. How often during the last 12 months have you had a feeling of guilt or remorse after drinking?
- NEVER  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY
32. How often during the last 12 months have you been unable to remember what happened the night before because you had been drinking?
- NEVER  WEEKLY  
 LESS THAN MONTHLY  DAILY OR ALMOST DAILY  
 MONTHLY
33. 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
34. 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
35. How many drinks of alcohol does it take for you to begin to feel a buzz or high?
- Have never felt a buzz or high  1  2  3  4  5  6  7  Greater than 8
36. How many drinks of alcohol does it take for you to begin to lose control or feel drunk?
- Have never felt this way  1  2  3  4  5  6  7  8  9  Greater than 10
37. 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.
- HAVE ALREADY CHANGED  NOT SURE  
 THINKING ABOUT CHANGING  NOT THINKING ABOUT CHANGING  
 NOT READY

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**PRESCRIPTION DRUG USE**

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

YES

NO (If NO, please skip to #41)

**39. 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.**

	<u>ANY LIFETIME USE</u>	<u>HAVE USED IN PAST 12 MONTHS</u>
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

40. 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**

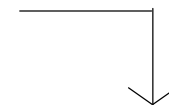
41. For each of the following drugs, please fill in the circle that best indicates how often in the past 12 months you used each drug.

**IN THE LAST 12 MONTHS**

	<b>HAVE NEVER TRIED</b>	<b>NO USE IN THE LAST YEAR</b>	<b>LESS THAN ONCE A MONTH</b>	<b>1 - 3 TIMES A MONTH</b>	<b>1 - 3 TIMES A WEEK</b>	<b>4 - 6 TIMES A WEEK</b>	<b>EVERY DAY</b>
a. Marijuana or Hashish	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Cocaine or Crack	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Stimulants (amphetamines, uppers, speed, crank, crystal meth, bam)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Heroin	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Prescription painkillers (such as Oxycontin, Vicodin, Percocet)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Prescription benzodiazepines (Valium, Deostat, Ativan)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Other	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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

- YES (If YES, please answer #43)  
 NO (If NO, please skip to #44)  
 DID NOT USE DRUGS (Please skip to #47)



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

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

44. 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?

- YES  
 NO

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45. 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.

YES  NO

46. 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.

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

**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.**

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

YES  NO (If NO, skip to question #66)

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

YES  NO

49. During the past 12 months, have you had sex with only males, only females, or with both males and females?

ONLY MALES  ONLY FEMALES  BOTH MALES AND FEMALES

50. How many sexual partners have you had in the last 12 months?

0  1  2  3  4  5  6  7  8 or more

51. 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  1  2  3  4  5  6  7  8 or more

52. In the past 12 months, have you used any prescription drug to improve sexual performance, such as Viagra, Cialis or Levitra?

YES  NO

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

YES  NO

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

YES  NO

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

YES  NO

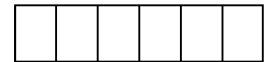
56. In the past 12 months, have you had unprotected sex (not used a condom) because you were drinking alcohol?

YES  NO

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57. In the past 12 months, have you had unprotected sex (not used a condom) because you were using drugs?  
 YES  NO
58. In the past 12 months, have you had unprotected sex (not used a condom) with someone you know has multiple partners?  
 YES  NO  Unsure
59. In the past 12 months, have you had unprotected sex (not used a condom) with someone who injects drugs?  
 YES  NO  Unsure
60. In the past 12 months have you paid for sex?  
 YES  NO
61. In the past 12 months have you been paid for sex ?  
 YES  NO
62. In the past 12 months have you been diagnosed with a sexually transmitted disease?  
 YES  NO
63. 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?  
 YES  NO  Unsure
64. In the past 12 months have you had unprotected sex (not used a condom) with someone you know who has the HIV virus?  
 YES  NO  Unsure
65. 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?

	<u>Yes</u>	<u>No</u>
a. A main partner (spouse or long-term lover)	0	0
If yes, did you use a condom every time?	0	0
b. Any other partner (date, fling, someone you just met)	0	0
If yes, did you use a condom every time?	0	0
c. Any partner who was HIV positive	0	0
If yes, did you use a condom every time?	0	0
d. Any partner who was HIV negative	0	0
If yes, did you use a condom every time?	0	0
e. Any partner whose HIV status was unknown	0	0
If yes, did you use a condom every time?	0	0

**HEALTH CARE**

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

	<b>VA</b>	<b>OUTSIDE CARE</b>	<b>DOES NOT APPLY</b>
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

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

	<b>VA</b>	<b>OUTSIDE CARE</b>	<b>DOES NOT APPLY</b>
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

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

- |  |  |
|--|--|
| <input type="checkbox"/> UNABLE TO GET APPOINTMENT WITH VA CARE    | <input type="checkbox"/> LOCATION      |
| <input type="checkbox"/> RELATIONSHIP WITH PROVIDER OUTSIDE THE VA | <input type="checkbox"/> INSURANCE     |
| <input type="checkbox"/> DISSATISFACTION WITH VA CARE              | <input type="checkbox"/> OTHER REASONS |
| <input type="checkbox"/> DID NOT RECEIVE CARE OUTSIDE THE VA       |  |

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

	<b><u>YES</u></b>	<b><u>NO</u></b>
a. For alcohol?	0	0
b. For drugs?	0	0
c. For HIV related problems?	0	0

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

- |  |   |
|--|---|
| <input type="checkbox"/> A PRIEST / MINISTER / RABBI OR OTHER CLERGY | <input type="checkbox"/> EMERGENCY ROOM             |
| <input type="checkbox"/> AN EMPLOYEE ASSISTANCE PROGRAM              | <input type="checkbox"/> OTHER                      |
| <input type="checkbox"/> ALCOHOLICS ANONYMOUS                        | <input type="checkbox"/> DID NOT RECEIVE COUNSELING |



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

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

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

	<u>NOT AT ALL</u>	<u>SEVERAL DAYS</u>	<u>MORE THAN HALF THE DAYS</u>	<u>NEARLY EVERY DAY</u>
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

73. 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?

- NOT DIFFICULT AT ALL
  VERY DIFFICULT  
 SOMEWHAT DIFFICULT
  EXTREMELY DIFFICULT

74. Have you ever seriously thought about committing suicide?  YES  NO

If YES, have you felt this way in the past 2 weeks?  YES  NO

75. Have you ever made a plan for committing suicide?  YES  NO

If YES, have you felt this way in the past 2 weeks?  YES  NO

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76. Have you ever attempted suicide?  YES  NO

If YES, have you felt this way in the past 2 weeks?  YES  NO

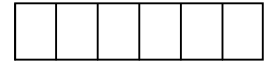
77. These questions are about any physical limitation you might have. For these activities, please indicate which response best describes you by filling in the circle under the appropriate response after each statement.

	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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Can you do moderate work at home like moving a chair or table, or pushing a vacuum cleaner?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Can you do light work around the house like dusting or washing dishes?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. If you want to, can you participate in active sports such as swimming, tennis, basketball, volleyball, or rowing a boat?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. If you want to, can you run a short distance?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Can you walk uphill or upstairs?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Can you walk a block or more?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Can you walk around inside the house?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Can you walk to a table for meals?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Can you dress yourself?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Can you eat without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Can you use the bathroom without help?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

**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.**

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

EXCELLENT  VERY GOOD  GOOD  FAIR  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 <u>A LOT</u>	YES, LIMITED <u>A LITTLE</u>	NO, NOT LIMITED <u>AT ALL</u>
79. Moderate activities, such as moving a table, pushing a vacuum cleaner, bowling, or playing golf	0	0	0
80. 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?

81. Accomplished less than you would like

YES  NO

82. Were limited in the kind of work or other activities

YES  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)?

83. Accomplished less than you would like

YES  NO

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

YES  NO

85. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

NOT AT ALL       MODERATELY       EXTREMELY  
 A LITTLE BIT       QUITE A BIT

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 -

	<u>ALL OF THE TIME</u>	<u>MOST OF THE TIME</u>	<u>A GOOD BIT OF THE TIME</u>	<u>SOME OF THE TIME</u>	<u>A LITTLE OF THE TIME</u>	<u>NONE OF THE TIME</u>
86. Have you felt downhearted and blue?	0	0	0	0	0	0
87. Did you have a lot of energy?	0	0	0	0	0	0
88. Have you felt calm and peaceful?	0	0	0	0	0	0



89. 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.)?

- ALL OF THE TIME                       A LITTLE OF THE TIME  
 MOST OF THE TIME                       NONE OF THE TIME  
 SOME OF THE TIME

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

	<b>STRONGLY AGREE</b>	<b>AGREE</b>	<b>NEITHER AGREE NOR DISAGREE</b>	<b>DISAGREE</b>	<b>STRONGLY DISAGREE</b>
a. I think HIV causes AIDS.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. HIV is a man-made virus.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. The medicines used to treat HIV are saving lives.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. There is a cure for AIDS, but it is being withheld from the poor.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. HIV was created and spread by the government.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. AIDS is a form of genocide against blacks.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. The medicine that doctors prescribe to treat HIV is poison.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. AIDS was created by the government to control the black population.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

91. Do you take any medicine to treat your HIV infection?

- YES       NO (If No, skip to question #93)

92. For some people it is difficult to always take medications as the doctor prescribes. Thinking back on the last month, on average how would you rate your ability to take ALL of your HIV medications as your doctor prescribed them?

- EXCELLENT                       FAIR  
 VERY GOOD                       POOR  
 GOOD                               VERY POOR





93. The following questions ask about your perceptions of alcohol use and your health.

	<b>STRONGLY AGREE</b>	<b>AGREE</b>	<b>NEITHER AGREE NOR DISAGREE</b>	<b>DISAGREE</b>	<b>STRONGLY DISAGREE</b>
a. People are more likely to miss taking their HIV medications if they have been drinking.	0	0	0	0	0
b. Alcohol and HIV medications should never be mixed.	0	0	0	0	0
c. Drinking in moderation can have health benefits, even for people with HIV.	0	0	0	0	0
d. A person should stop taking their HIV medications if they are going to be drinking.	0	0	0	0	0

**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:**

	<b>COMPLETELY</b>	<b>MOSTLY</b>	<b>SOMEWHAT</b>	<b>A LITTLE</b>	<b>NOT AT ALL</b>
94. How much do you trust your doctor to offer you high quality medical care?	0	0	0	0	0
95. How much do you trust your doctor to know all about the very best treatments and care for HIV?	0	0	0	0	0
96. How much do you trust your doctor to give you enough information about your condition to make decisions?	0	0	0	0	0
97. How much do you trust your doctor to keep personal information private?	0	0	0	0	0
98. 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
99. 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
100. How much do you trust your doctor to put your needs ahead of scientific research goals?	0	0	0	0	0



**The next set of questions are about your experiences with the internet.**

101. In the last 12 months did you use the Internet for any purpose?

- YES     NO (If No, skip to the end of the survey)

102. In the last 12 months, about how often did you look on the Internet for information or advice about health or health care?

- MORE THAN ONCE A WEEK     EVERY 2-3 MONTHS  
 ABOUT ONCE A WEEK     LESS THAN EVERY 2-3 MONTHS  
 ONCE A MONTH     NEVER (If Never, skip to the end of the survey)

103. In the last 12 months, did you use the Internet to obtain information about your HIV medications?

- YES     NO     NOT CURRENTLY TAKING MEDICATIONS FOR HIV

104. In the last 12 months did you use the Internet to obtain information about your medications (non HIV)?

- YES     NO     NOT CURRENTLY TAKING ANY MEDICATIONS

105. In the last 12 months did you use the Internet to obtain information about your HIV disease?

- YES     NO

106. In the last 12 months, did you use the Internet to obtain information about your medical conditions(non HIV) ?

- YES     NO

107. Thinking about all of the times in the last year that you used the Internet for things related to health or health care, to what extent do you agree or disagree with the following statement, "Using the Internet improved my ability to manage my health care needs."

- |                       |                       |                               |                       |                       |
|-----------------------|-----------------------|-------------------------------|-----------------------|-----------------------|
| STRONGLY<br>AGREE     | AGREE                 | NEITHER AGREE<br>NOR DISAGREE | DISAGREE              | STRONGLY<br>DISAGREE  |
| <input type="radio"/> | <input type="radio"/> | <input type="radio"/>         | <input type="radio"/> | <input type="radio"/> |

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**MyHealthVet (www.myhealth.va.gov) is a VA website that veterans can use to find health information and do things like ordering VA prescription refills**

108. In the last 12 months, about how often did you use the MyHealthVet website for information or advice about health or health care, or to refill prescriptions?

- MORE THAN ONCE A WEEK       EVERY 2-3 MONTHS  
 ABOUT ONCE A WEEK             LESS THAN EVERY 2-3 MONTHS  
 ONCE A MONTH                     NEVER (If Never, skip to the end of the survey)

109. Thinking about all of the times in the last year that you used the MyHealthVet website, to what extent do you agree or disagree with the following statement, "Using the MyHealthVet website improved my ability to manage my health care needs."

- |                        |            |                                    |               |                           |
|------------------------|------------|------------------------------------|---------------|---------------------------|
| STRONGLY<br>AGREE<br>0 | AGREE<br>0 | NEITHER AGREE<br>NOR DISAGREE<br>0 | DISAGREE<br>0 | STRONGLY<br>DISAGREE<br>0 |
|------------------------|------------|------------------------------------|---------------|---------------------------|

**Thank you for completing our questionnaire.**