

ID # _____ RA: _____ Study Site _____

Florida Cohort Follow-Up Survey

**Thank you for taking the time to fill out our Follow-up
survey!**

**There are no wrong or right answers, so we hope that
you will feel comfortable answering each question as
honestly as possible.**

Thanks again,

The Florida Cohort Study Team

INSURANCE/DOMESTIC INFORMATION

To get started, we are going to ask several questions that help us to describe you and your health care. Some of the questions will be similar to those you completed on the first survey and some will be different.

1. Please check all the types of health insurance you currently have.

- Private Insurance
- Medicaid
- AIDS Drug Assistance Program (ADAP)
- Tricare or CHAMPUS
- Veterans Administration (VA) Coverage
- Public Health Care ('Obama Care')
- Medicare
- Ryan White
- Uninsured
- Other: _____
- I do not know

2. Check all of the places that you have lived in the past 6 months

- Own apartment or house
- Rented room, apartment, or house
- Stayed with family or friends
- Housing Options for People with AIDS (HOPWA)
- Substance abuse treatment facility
- Psychiatric facility
- Jail, prison, or detention facility
- Homeless shelter, Halfway houses or Transitional housing
- Hospital
- Emergency shelter (such as a domestic violence shelter, church, or motel voucher)
- Car, street, or abandoned building

This next set of questions will ask how you feel about your health.

1. Overall, how would you rate your health in the past 4 weeks?

- Excellent
- Very good
- Good
- Fair
- Poor
- Very Poor

2. During the past 4 weeks, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do physical activities

3. During the past 4 weeks, how much difficulty did you have doing your daily work, both at home and away from the home, because of your physical health?

- None at all
- A little bit
- Somewhat
- Quite a lot
- Could not do daily work

4. How much bodily pain have you had in the past 4 weeks?

- None
- Very mild
- Mild
- Moderate
- Severe
- Very Severe

5. During the past 4 weeks, how much energy did you have?

- Very much
- Quite a lot
- Some
- A little
- None

6. During the past 4 weeks, how much did your physical health or emotional problems limit your usual social activities with family or friends?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do social activities

7. During the past 4 weeks, how much have you been bothered by emotional problems (such as feeling anxious, depressed or irritable)?

- None at all
- Slightly
- Moderately
- Quite a lot
- Extremely

8. During the past 4 weeks, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

- Not at all
- Very little
- Somewhat
- Quite a lot
- Could not do daily activities

9. Considering a 7-day period (a week), during your leisure-time how often do you engage in any regular activity long enough to work up a sweat (Your heart beats rapidly)?

- Never
- Rarely
- Sometimes
- Often

HEALTHCARE SERVICES

In this next section, we are going to ask several questions related to how you receive the healthcare services you need.

Please circle your response to indicate the number of times during the last 6 months you had to do each of the following:

CIRCLE ONE NUMBER FOR EACH QUESTION					
1.	Stay at a hospital for at least one night	0	1	2	3+
2.	Go to an emergency room or urgent care center for medical care	0	1	2	3+
3.	Visit a mental health provider (like a psychiatrist, psychologist, social worker)	0	1	2	3+
4.	Visit a dental care provider (like a dentist, dental or oral surgeon, orthodontist)	0	1	2	3+
5.	Be taken care of by a friend or family member because you were ill	0	1	2	3+

EMOTIONAL WELL-BEING/SUPPORT

In this next section, we are going to ask several questions related to the amount of emotional support you have available.

PLEASE CHECK ONE BOX TO INDICATE HOW OFTEN EACH OF THE FOLLOWING OCCUR.		<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Usually</i>	<i>Always</i>
1.	I have someone who will listen to me when I need to talk.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I have someone to confide in or talk to about myself or my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I have someone who makes me feel appreciated.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I have someone to talk with when I have a bad day.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I have someone who understands my problems.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I have someone I trust to talk about my feelings.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

People differ in the ways they act and think in different situations.

PLEASE CHECK ONE BOX TO INDICATE HOW OFTEN EACH OF THE FOLLOWING OCCUR.		Never	Occasionally	Often	Almost Always or Always
1.	I plan tasks carefully	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I do things without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I don't pay attention	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I am self-controlled	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I concentrate easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I am a careful thinker	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I say things without thinking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	I act on the spur of the moment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The next set of questions asks about how often you have felt different feelings in the past 7 days. Please respond to each item by marking one box per row.

IN THE PAST 7 DAYS...		<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Always</i>
1.	I felt fearful	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	I felt anxious	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	I felt worried	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	I found it hard to focus on anything other than my anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	I felt nervous	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	I felt uneasy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	I felt tense	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

PAIN

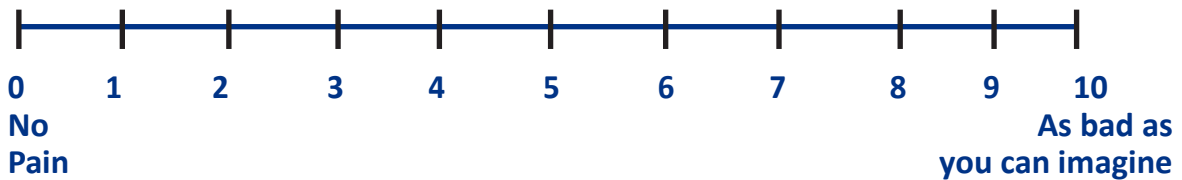
Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). We are going to ask some question about how much pain impacts your life.

1. Have you had pain other than minor everyday kinds of pain in the past 24 hours?

- Yes
 No

SKIP TO PLANNING SECTION, PAGE 11

Please use the scale below and choose the answers that best describe your pain in the past 24 hours.



Rate your pain:

2. At its WORST	0	1	2	3	4	5	6	7	8	9	10
3. At its LEAST	0	1	2	3	4	5	6	7	8	9	10
4. On AVERAGE	0	1	2	3	4	5	6	7	8	9	10
5. RIGHT NOW	0	1	2	3	4	5	6	7	8	9	10

6. Are you taking any treatment or medication for your pain?

No

SKIP TO QUESTION 7

Yes

6a. Was this treatment or medication prescribed to you by a healthcare professional?

Yes

No

6b. Please describe this treatment or medication:

IN THE PAST 7 DAYS...

Not at all

A little bit

Somewhat

Quite a lot

Very much

7. How much did pain interfere with your day to day activities?

8. How much did pain interfere with work around the home?

9. How much did pain interfere with your ability to participate in social activities?

10. How much did pain interfere with your household chores?

PLANNING

People have different experiences related to planning. Please check a box for each row to indicate how much difficulty you currently have for each of the following.

HOW MUCH DIFFICULTY DO YOU CURRENTLY HAVE....	<i>None</i>	<i>A little</i>	<i>Somewhat</i>	<i>A lot</i>	<i>Cannot perform</i>
1. Reading and following complex instructions (e.g. directions for a new medication)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Planning for and keeping appointments that are not part of your weekly routine (e.g. social gatherings)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Managing your time to do most of your daily activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Learning new tasks or instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SLEEP

The next series of questions are about your sleep.

1. In the past 7 days, my sleep quality was...

- Very Poor
- Poor
- Fair
- Good
- Very Good

The next series of questions are about how often each of the following have happened in the past 7 days.

IN THE PAST 7 DAYS...	<i>Not at all</i>	<i>A little bit</i>	<i>Somewhat</i>	<i>Quite a bit</i>	<i>Very much</i>
2. My sleep was refreshing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. I had a problem with my sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. I had difficulty falling asleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. My sleep was restless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. I tried hard to get to sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SUBSTANCE USE

Many people smoke, drink, or use other types of drugs, others do not. This section will ask about substances that you have used in the past 6 months.

Smoking

FOR EACH OF THE FOLLOWING DRUGS PLEASE MARK THE RESPONSE THAT BEST DESCRIBES HOW OFTEN YOU USED EACH DRUG								
		Never	Not in the past 6 months	Less than once a month	1-3 times a month	1-3 times a week	4-6 times a week	Everyday
1.	Cigars	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Eleconronic cigarette (e-cig or e-cigarette), personal vaporizer (PV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Nicotine delivery system (ENDS)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Hookah	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

5. Do you currently smoke cigarettes?

- Yes
 No

SKIP TO ALCOHOL USE SECTION, PAGE 14

6. On average, in the past 6 months how much do you currently smoke?

- Less than 10 cigarettes a day (less than ½ a pack)
 10-20 cigarettes a day (½ to 1 pack)
 21 – 30 cigarettes a day (over 1 pack to 1 ½ pack)
 31 – 40 cigarettes a day (over 1 ½ to 2 packs)
 40 cigarettes a day (over 2 packs)

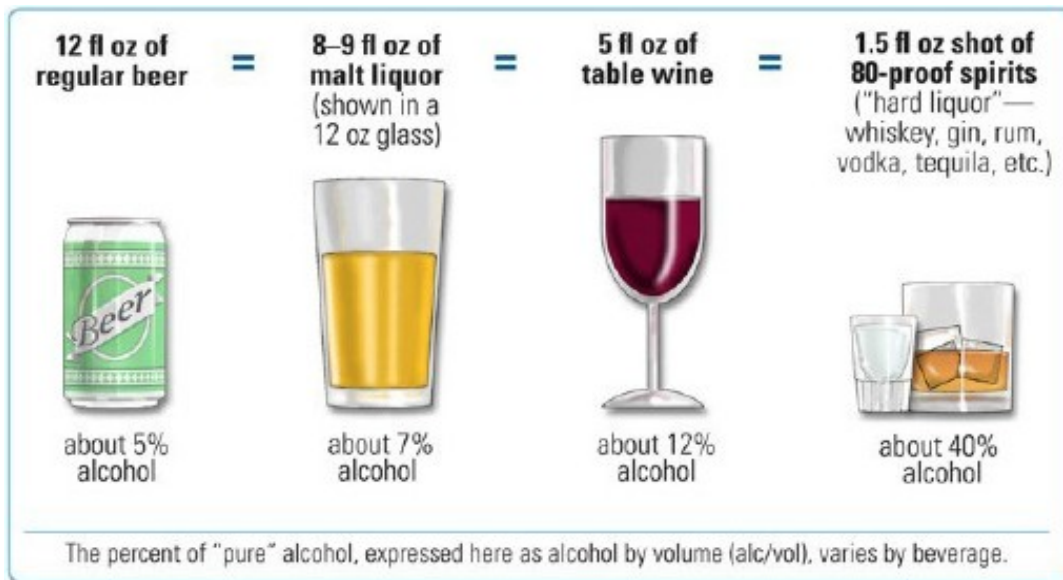
7. What are your thoughts about quitting smoking?

- I am not interested in quitting at this time
 I would like to quit sometime, but not now
 I am currently trying to quit smoking

Alcohol Use

1. In the past 6 months how often did you have a drink containing alcohol?

- I have not drunk any alcohol in the past 6 months **SKIP TO PAGE 18, QUESTION 1**
- Less than once a month
- 1-3 times a month (less than weekly)
- 1-3 times a week
- 4-6 times a week
- Everyday



TRY TO ANSWER THE NEXT QUESTIONS IN TERMS OF 'STANDARD DRINKS' SHOWN IN THE PICTURE ABOVE.

IN THE PAST 6 MONTHS....		Number of Drinks				
2.	How many standard drinks would you have on a typical day when you were drinking?	1-2	3-4	5-6	7-9	10+

3. In the past 6 months, how often did you have 4 (or more) standard drinks (for women) or 5 (or more) standard drinks (for men) on one occasion?

- Never
- Less than once a month
- Monthly
- Weekly
- Daily or almost daily

Alcohol Use Continued

4. During the last 30 days (month), what is the largest number of drinks containing alcohol that you drank within a 24-hour period?

- | | |
|--|--|
| <input type="checkbox"/> Less than 1 drink | <input type="checkbox"/> 8 to 11 drinks |
| <input type="checkbox"/> 1 drink | <input type="checkbox"/> 12 to 17 drinks |
| <input type="checkbox"/> 2 drinks | <input type="checkbox"/> 18 to 23 drinks |
| <input type="checkbox"/> 3 drinks | <input type="checkbox"/> 24 to 35 drinks |
| <input type="checkbox"/> 4 drinks | <input type="checkbox"/> 36 drinks or more |
| <input type="checkbox"/> 5 to 7 drinks | |

5. What are your thoughts about cutting back on drinking alcohol?

- I am not interested in cutting back on my drinking at this time.
- I would like to cut back on my drinking sometime, but not now
- I am currently trying to cut back on my drinking

6. In the past 6 months, check all of the following treatments or strategies that you used to help you stop or cut back on your drinking.

- Alcoholics Anonymous (AA)
- Counseling or therapy
- “Detox” or alcohol treatment in an outpatient or community setting
- “Detox” or alcohol treatment in an inpatient setting
- Medication to help reduce drinking
- None of the above

7. In the past week, did you drink any alcoholic beverage, including beer or wine, to relieve pain?

- Yes
- No **SKIP TO NEXT PAGE, QUESTION 9**

8. How much pain relief did drinking the alcohol beverage provide?

- None
- Some relief
- Moderate relief
- Almost complete relief
- Complete relief

Alcohol Use Continued

IN THE PAST 6 MONTHS, WHEN YOU DRANK ALCOHOL HOW OFTEN DID YOU CONSUME THE FOLLOWING TYPES OF ALCOHOL?	<i>Never</i>	<i>Rarely</i>	<i>Often</i>
9. Beer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Red Wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
11. Other wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
12. Liquor or mixed drink	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

People have different experiences when they drink alcohol. Please think about your experiences with alcohol in the past 30 days.

IN THE PAST 30 DAYS...	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Almost Always</i>
13. I was able to express myself better when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. I was unreliable after I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
15. I felt at ease when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
16. Others complained about my drinking.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
17. I felt good about myself when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
18. Drinking created problems between me and others.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Alcohol Use Continued

People have different experiences when they drink alcohol. Please think about your experiences with alcohol in the past 30 days.

IN THE PAST 30 DAYS...	<i>Never</i>	<i>Rarely</i>	<i>Sometimes</i>	<i>Often</i>	<i>Almost Always</i>
19. I felt creative when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20. I said or did embarrassing things when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
21. I felt outgoing when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
22. I disappointed others when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. I felt confident when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. I used poor judgment when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
25. I had more fun when I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. I had trouble getting things done after I drank.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Marijuana Use

1. On average, how often have you used marijuana in the past 6 months?

- I did not use in the past 6 months **SKIP TO OTHER DRUG USE SECTION, PG 21, QUESTION 1**
- Less than once a month
- 1-3 times a month (less than weekly)
- 1-3 times a week
- 4-6 times a week
- Everyday

2. In the past 6 months, on the days that you did use, how many times did you use on average?

- Once
- Twice
- 3 times
- 4 times
- 5 or more times

3. In the past 6 months, how did you consume marijuana? (Check all that apply)

- Joints [marijuana cigarettes made with rolled paper]
- Blunts [cigar wrappers filled with marijuana and/or tobacco]
- Pipes [water-pipes, bongs, hookahs, one-hitters, etc.]
- Ingestion by eating or drinking [as a tea, or in a cookie or brownie, etc.]
- Vaporizing devices

4. What are your thoughts about cutting back on using marijuana?

- I am not interested in cutting back on marijuana use at this time.
- I would like to cut back on my use of marijuana sometime, but not now
- I am currently trying to cut back on my use of marijuana

Marijuana Use Continued

5. Considering your use of marijuana in the past 6 months:

a. Have you found that you needed to use more marijuana in order to get the same effect that you got when you first started using marijuana? Yes
 No

b. When you reduced or stopped using marijuana, did you have aches, shaking, fever, weakness, diarrhea, nausea, sweating heart pounding, difficulty sleeping, or feeling agitated, anxious, irritable, or depressed)? Yes
 No

c. Have you often found that when you use marijuana you ended up taking more than you thought you would? Yes
 No

d. Have you tried to reduce or stop taking marijuana but failed? Yes
 No

e. On the days that you used marijuana, did you spend substantial time (>2 hours), obtaining, using or in recovering from the effects of the marijuana you used? Yes
 No

f. Did you spend less time working, enjoying hobbies, or being with family or friends because of your marijuana use? Yes
 No

g. Have you continued to use marijuana, even though it has caused you health or mental problems? Yes
 No

h. Have you been intoxicated, high, or hung over from marijuana more than once when you had other responsibilities at school, work, or at home? Yes
 No

i. Have you been high or intoxicated from marijuana more than once in any situation where you were physically at risk (for example, driving a car, riding a motorbike, using machinery, boating etc.)? Yes
 No

j. Have you found a strong desire to use marijuana that you couldn't resist it or think of anything else? Yes
 No

Marijuana Use Continued

SINCE YOUR LAST VISIT, HOW OFTEN WAS YOUR USE OF MARIJUANA FOR MEDICAL REASON; FOR EXAMPLE TO HELP:	<i>Never</i>	<i>Rarely</i>	<i>Often</i>
6. To improve my appetite/gain weight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Induce sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Relieve nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Relieve pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Relieve anxiety/depression/stress	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SINCE YOUR LAST VISIT, HOW OFTEN WAS YOUR USE OF MARIJUANA FOR RECREATIONAL REASONS; FOR EXAMPLE TO:	<i>Never</i>	<i>Rarely</i>	<i>Often</i>
12. Get high or stoned	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
13. Fit into social situations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
14. Improve your sexual performance/libido	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other Drug Use

FOR EACH OF THE FOLLOWING DRUGS PLEASE MARK THE RESPONSE THAT BEST DESCRIBES HOW OFTEN YOU USED EACH DRUG		<i>Not in the past 6 months</i> <i>Less than once a month</i> <i>1-3 times a month</i> <i>1-3 times a week</i> <i>Everyday</i>				
1.	Injected Heroin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Injected Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Injected Stimulants (like Methamphetamine)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Snorted Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5.	Smoked Crack Cocaine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Stimulants or “uppers” (like methamphetamine, speed, “crank”)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Pain medication (like Oxycontin)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8.	Sedatives or “downers” (like Valium or Xanax)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9.	Ecstasy or Molly	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SEXUAL HISTORY

People with HIV have a variety of sexual experiences. Some people have sex with many others, some people have no sex at all.

1. During the past 6 months, with whom have you ever had sex (including oral sex)?

- Men only
- Men and women
- Women only
- No one

SKIP TO OTHER HEALTH CONDITIONS, PAGE 25

IN THE PAST 6 MONTHS, HAVE YOU HAD ANY ANAL OR VAGINAL SEX WITH ANY OF THE FOLLOWING TYPES OF PARTNERS?	No	Yes - Always with a condom	Yes - without a condom at least once
2. A main partner (spouse or long-term lover)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Any other partner who you knew (friend or acquaintance)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Any other partner whom you did not know (anonymous sex or someone you just met)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Any partner who was HIV positive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Any partner who was HIV negative	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Any partner whose HIV status was unknown or you were not sure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
8. Any partner whom you received money or drugs in exchange for sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Any partner whom you provided money or drugs in exchange for sex	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>



ATTENTION:

If you currently have a penis complete this section, otherwise skip to next page, PAGE 24.

Please indicate the number of partners you had in the past 6 months for each of the following types of sexual behavior.

Sexual activity <u>with women</u>	Number of partners						
1. Oral sex (a women’s mouth on my penis and/or my mouth on a woman’s vagina)	0	1	2	3	4	5	6+
2. Vaginal sex – my penis in a woman’s vagina	0	1	2	3	4	5	6+
3. Penetrative anal sex – my penis in a woman’s anus (buttocks)	0	1	2	3	4	5	6+
Sexual activity <u>with men</u>	Number of partners						
4. Oral sex (a man’s mouth on my penis and/or my mouth on a man’s penis)	0	1	2	3	4	5	6+
5. Penetrative anal sex – my penis in a man’s anus (buttocks)	0	1	2	3	4	5	6+
6. Receptive anal sex – a man’s penis in my anus (buttocks)	0	1	2	3	4	5	6+



ATTENTION:

If you currently have a vulva/vagina complete this section, otherwise skip to next page, PAGE 25.

Please indicate the number of partners you had in the past 6 months for each of the following types of sexual behavior.

Sexual activity <u>with men</u>		Number of partners						
1.	Oral sex (a man’s mouth on my vagina and/or my mouth on a man’s penis)	0	1	2	3	4	5	6+
2.	Vaginal sex – a man’s penis in my vagina	0	1	2	3	4	5	6+
3.	Anal sex – a man’s penis in my anus (buttocks)	0	1	2	3	4	5	6+
Sexual activity <u>with women</u>		Number of partners						
4.	Oral sex (a woman’s mouth on my vagina and/or my mouth on a woman’s vagina)	0	1	2	3	4	5	6+
5.	Sex with a toy that was shared with another woman	0	1	2	3	4	5	6+

6. What is your current pregnancy status?

- I am currently pregnant
- I cannot become pregnant any more
- I am trying to become pregnant
- I am not sure if I want to become pregnant
- I am trying to prevent pregnancy
- Not Applicable

OTHER HEALTH CONDITIONS

Testing for Cancer

People sometimes get tests for different types of cancer. Have you ever received any of the following types of tests?

ATTENTION: Women please answer Questions 1 - 4. Men please answer Questions 5 - 7

FOR EACH OF THE FOLLOWING TESTS PLEASE MARK THE RESPONSE THAT BEST DESCRIBES WHEN YOU LAST HAD ONE DONE, IF EVER:			<i>Never</i>	<i>Yes- within past 3 years</i>	<i>Yes- more than 3 years ago</i>	<i>Not Sure</i>
1.	Mammogram (breast cancer test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2.	Colonoscopy (colon cancer test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3.	Pap smear (gynecology exam – cervix cancer test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4.	Anal pap test (test for anal cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

ATTENTION: Men please answer Questions 5 - 7. Women please skip to next page.

FOR EACH OF THE FOLLOWING TESTS PLEASE MARK THE RESPONSE THAT BEST DESCRIBES WHEN YOU LAST HAD ONE DONE, IF EVER:			<i>Never</i>	<i>Yes- within past 3 years</i>	<i>Yes- more than 3 years ago</i>	<i>Not Sure</i>
5.	Prostate (prostate cancer test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6.	Colonoscopy (colon cancer test)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7.	Anal pap test (test for anal cancer)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Relationships

Now I'm going to ask you about partners. By 'main partner', I mean a person you feel committed to above anyone else.

1. Are you currently in a relationship with a main partner (in a serious relationship)?

Yes

No **SKIP TO NEXT PAGE, QUESTION 9**

2. How long have you been in a relationship with this main partner?

< 3 months

3-6 months

6 months to 1 year

1 year to 5 years

more than 5 years

6. How confident are you that you know this persons' HIV serostatus?

Very confident

Somewhat confident

Not confident

7. What is the person's HIV status? (whether they are positive or negative).

HIV-positive

HIV-negative

I'm not sure

8. People use different strategies to avoid getting HIV infection from another person. Please check each of the strategies that YOU use to prevent you from getting HIV infection from your main sexual partner (in a serious relationship)?

- I don't have a main sexual partner
- My main partner does not have HIV infection
- We don't have sex
- I take PrEP
- My partner takes medications to suppress the HIV virus to undetectable
- We use condoms
- We avoid certain kinds of sex that are more risky
- Any other method? (explain) _____
- No strategy

Casual Partners

9. Please check each of the strategies that YOU use to prevent you from getting HIV from a casual partner (not in a serious relationship)?

- I don't have any casual partners
- I am sure that none of my casual partners have HIV infection
- I take PrEP
- I only have sex with someone who has undetectable HIV virus
- We use condoms
- We avoid certain kinds of sex that are more risky
- Any other method? (explain) _____
- No strategy

PrEP

The following questions ask you about a medication called PrEP (also known by the brand name Truvada). PrEP is an oral medication used by a person without HIV to reduce their chances of becoming HIV positive. People who do not have HIV may take PrEP if they have sex with a partner who is HIV positive, or sex with partners who may be HIV positive. For PrEP to be effective, it must be taken every day and a doctor's visit is required every three months.

Awareness

1. Prior to this survey, had you heard of PrEP

- Yes
- No

2. Are you currently taking PrEP?

- Yes **Skip to question 7, page 29**
- No (continue below)

3. How difficult do you think it would be for you to take PrEP every day?

- Not difficult
- Somewhat not difficult
- Neither difficult or not difficult
- Somewhat difficult
- Difficult

4. If PrEP were available to you, how likely would you be to use it to prevent against transmission of HIV?

- Not Likely
- Somewhat not likely
- Neither likely or not likely
- Somewhat likely
- Likely

5. If you were taking PrEP daily, would you use condoms less frequently, more frequently, or about as frequently as before?

- Less frequently
- About as frequently as before
- More frequently
- Don't know

6. If you were taking PrEP daily, would you have sex with fewer people, more people, or about the same number of people?

- More people
- About the same number
- Fewer people

If you are currently taking PrEP please answer the following questions 7-13

7. When did you start taking PrEP

- Within the past 3 months
- More than 3 months ago but within the last year
- More than 1 year ago but less than 2 years ago
- More than 2 years ago

8. How regularly do you take PrEP?

- Less than once a month
- 1-3 times a month (less than weekly)
- 1-3 times a week
- 4-6 times a week
- Every day

9. How do you pay for PrEP? (Select all that apply)

- Gilead Co-Pay Card
- Patient Advocate Foundation
- Patient Access Network Foundation
- Medicare
- Medicaid
- Employer Insurance
- Private Insurance
- Other (please describe)_____

10. How much does your PrEP prescription cost per month? (the amount you personally have to pay?)

- Amount:_____

11. How difficult is it for you to take PrEP every day?

- Not difficult
- Somewhat not difficult
- Neither difficult or not difficult
- Somewhat difficult
- Difficult

12. Since you have been taking PrEP, do you use condoms less frequently, more frequently, or about as frequently as before?

- Less frequently
- About as frequently as before
- More frequently

13. Since you have been taking PrEP, do you have sex with fewer people, more people, or about the same number of people?

- Fewer people
- About the same number
- More people

Everyone please answer the following PrEP questions 14-19

14. Where did you first hear about PrEP? (Check One)

- This survey
- The news (eg., newspapers, TV)
- HIV/AIDS support group
- Spouse/main partner
- Friend/family member
- Public health organization
- My doctor
- The Internet (e.g., blogs, social media)
- Other (please describe)_____

15. Please select ONE source you would be most likely to use to find further information about PrEP.

- The news (e.g., newspapers, TV)
- HIV/AIDS support group
- Spouse/main partner
- Friend/family member
- Public health organization
- My doctor
- The Internet (e.g., blogs, social media)
- Other (please describe)_____

16. Please select ONE source you would trust most for information about PrEP.

- The news (e.g., newspapers, TV)
- HIV/AIDS support group
- Spouse/main partner
- Friend/family member
- Public health organization
- My doctor
- The Internet (e.g., blogs, social media)
- Other (please describe)_____

17. In your opinion, how safe do you think taking PrEP is?

- Not safe
- Somewhat not safe
- Neither unsafe or safe
- Somewhat safe
- Safe

18. PrEP is currently used to prevent transmission of HIV in couples who are trying to get pregnant naturally, but where one partner is HIV positive. How safe do you think PrEP is at preventing HIV transmission for couples who are trying to get pregnant?

- Not safe
- Somewhat not safe

- Neither unsafe or safe
- Somewhat safe
- Safe

18. How likely are you to suggest that someone you know take PrEP to prevent transmission of HIV?

- Not likely
- Somewhat not likely
- Neutral
- Somewhat likely
- Likely

19. How confident are you that taking PrEP every day would reduce the transmission of HIV?

- Not confident
- Somewhat not confident
- Neutral
- Somewhat confident
- Confident

20. Do you have any comments about this survey, or suggestions about topics we should be asking about?

**Thank you for taking the
time to fill out our
Follow-up survey!**