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+**

In this next section, we are going to ask several questions related to getting healthcare that is related to your HIV infection.

1. Are you currently taking HIV antiviral medication?

- ☐ Yes
- ☐ No → **1a. If not, why not?** **THEN SKIP TO THE EMOTIONAL WELL-BEING/ SUPPORT SECTION, PAGE 8**

(please describe) _____

2. In the last 30 days, on how many days did you miss at least one dose of any of your HIV medicine?

Write in number of days:_____(0-30)

3. In the last 30 days, how well did you do at remembering to take all your prescribed HIV medication?

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

4. In the last 30 days, how often did you take your HIV medication as directed?

- ☐ Always
- ☐ Almost Always
- ☐ Usually
- ☐ Sometimes
- ☐ Rarely
- ☐ Never

5. During the past 30 days, how often did you have side effects from your HIV medication?

- ☐ Always
- ☐ Most of the time
- ☐ About half the time
- ☐ Rarely
- ☐ Never

6. Are you taking any other medications or supplements to try to help with your HIV infection?

- ☐ No
- ☐ Yes, please list: _____

7. During the past 6 months, was there one usual place, like a doctor's office or clinic, where you go for most of your HIV health care?

- ☐ Yes
- ☐ No **SKIP TO QUESTION 10**

8. How satisfied are you with the clinic where you receive HIV care?

- ☐ Very dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Very Satisfied

9. How satisfied are you with your HIV care provider (the doctor or nurse)?

- ☐ Very dissatisfied
- ☐ Somewhat dissatisfied
- ☐ Satisfied
- ☐ Somewhat satisfied
- ☐ Very Satisfied

10. Have you changed HIV providers in the last 6 months?

- ☐ No
- ☐ Yes → 10a. **If so, why?**

_____

_____

_____

11. Have you missed any schedule HIV health care appointments in the past 6 months?

- ☐ Yes
- ☐ No

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.		Never	Rarely	Sometimes	Usually	Always
1.	I have someone who will listen to me when I need to talk.	☐	☐	☐	☐	☐
2.	I have someone to confide in or talk to about myself or my problems.	☐	☐	☐	☐	☐
3.	I have someone who makes me feel appreciated.	☐	☐	☐	☐	☐
4.	I have someone to talk with when I have a bad day.	☐	☐	☐	☐	☐
5.	I have someone who understands my problems.	☐	☐	☐	☐	☐
6.	I have someone I trust to talk about my feelings.	☐	☐	☐	☐	☐

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.				
1. I plan tasks carefully	☐	☐	☐	☐
2. I do things without thinking	☐	☐	☐	☐
3. I don't pay attention	☐	☐	☐	☐
4. I am self-controlled	☐	☐	☐	☐
5. I concentrate easily	☐	☐	☐	☐
6. I am a careful thinker	☐	☐	☐	☐
7. I say things without thinking	☐	☐	☐	☐
8. I act on the spur of the moment	☐	☐	☐	☐

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...	Never	Rarely	Sometimes	Often	Always
1. I felt fearful	☐	☐	☐	☐	☐
2. I felt anxious	☐	☐	☐	☐	☐
3. I felt worried	☐	☐	☐	☐	☐
4. I found it hard to focus on anything other than my anxiety	☐	☐	☐	☐	☐
5. I felt nervous	☐	☐	☐	☐	☐
6. I felt uneasy	☐	☐	☐	☐	☐
7. I felt tense	☐	☐	☐	☐	☐

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 PAGE 12, QUESTION 6

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

0 No Pain — **10 As bad as you can imagine**

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 PAGE 12, QUESTION 1**

☐ 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
1.	How much did pain interfere with your day to day activities?	☐	☐	☐	☐	☐
2.	How much did pain interfere with work around the home?	☐	☐	☐	☐	☐
3.	How much did pain interfere with your ability to participate in social activities?	☐	☐	☐	☐	☐
4.	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....	None	A little	Somewhat	A lot	Cannot perform
1.	Reading and following complex instructions (e.g. directions for a new medication)	☐	☐	☐	☐	☐
2.	Planning for and keeping appointments that are not part of your weekly routine (e.g. social gatherings)	☐	☐	☐	☐	☐
3.	Managing your time to do most of your daily activities.	☐	☐	☐	☐	☐
4.	Learning new tasks or instructions	☐	☐	☐	☐	☐

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...		Not at all	A little bit	Somewhat	Quite a bit	Very much
2.	My sleep was refreshing	☐	☐	☐	☐	☐
3.	I had a problem with my sleep	☐	☐	☐	☐	☐
4.	I had difficulty falling asleep	☐	☐	☐	☐	☐
5.	My sleep was restless	☐	☐	☐	☐	☐
6.	I tried hard to get to sleep	☐	☐	☐	☐	☐

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 month.

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	☐	☐	☐	☐	☐	☐	☐
2.	Elecontronic cigarette (e-cig or e-cigarette), personal vaporizer (PV)	☐	☐	☐	☐	☐	☐	☐
3.	Nicotine delivery system (ENDS)	☐	☐	☐	☐	☐	☐	☐
4.	Hookah	☐	☐	☐	☐	☐	☐	☐

5. Do you currently smoke cigarettes?

☐ Yes

☐ No

SKIP TO ALCOHOL USE SECTION, PAGE 16, QUESTION 1

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

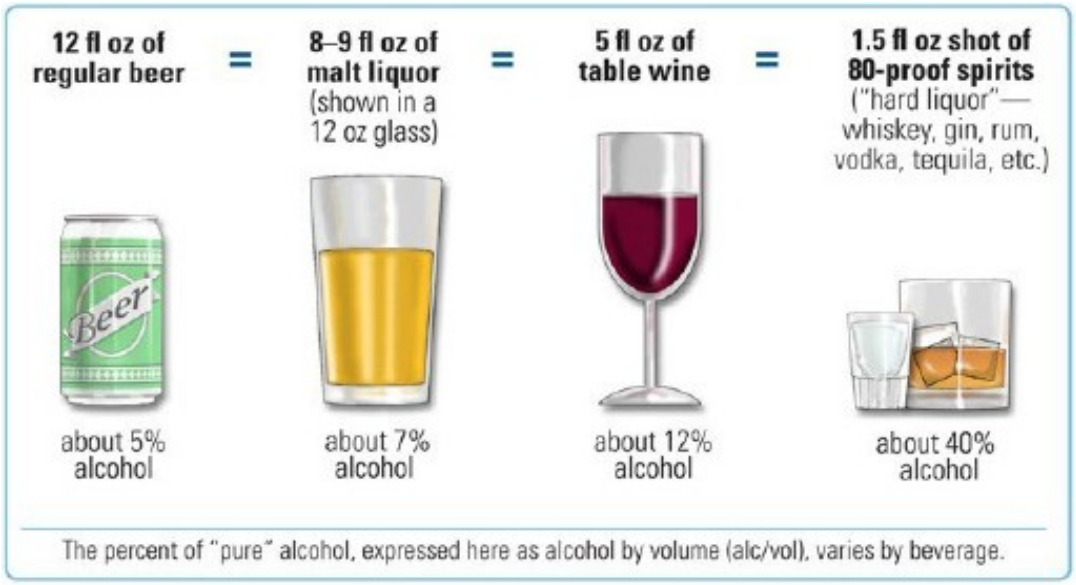
☐ I would like to quit sometime, but not now

☐ 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 drank any alcohol in the past 6 months **SKIP TO PAGE 20, 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 times				
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?

- ☐ Less than 1 drink
- ☐ 1 drink
- ☐ 2 drinks
- ☐ 3 drinks
- ☐ 4 drinks
- ☐ 5 to 7 drinks
- ☐ 8 to 11 drinks
- ☐ 12 to 17 drinks
- ☐ 18 to 23 drinks
- ☐ 24 to 35 drinks
- ☐ 36 drinks or more

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?	Never	Rarely	Often
9. Beer	☐	☐	☐
10. Red Wine	☐	☐	☐
11. Other wine	☐	☐	☐
12. Liquor or mixed drink	☐	☐	☐

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...	Never	Rarely	Sometimes	Often	Almost Always
13. I was able to express myself better when I drank.	☐	☐	☐	☐	☐
14. I was unreliable after I drank.	☐	☐	☐	☐	☐
15. I felt at ease when I drank.	☐	☐	☐	☐	☐
16. Others complained about my drinking.	☐	☐	☐	☐	☐
17. I felt good about myself when I drank.	☐	☐	☐	☐	☐
18. Drinking created problems between me and others.	☐	☐	☐	☐	☐

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...	Never	Rarely	Sometimes	Often	Almost Always
19. I felt creative when I drank.	☐	☐	☐	☐	☐
20. I said or did embarrassing things when I drank.	☐	☐	☐	☐	☐
21. I felt outgoing when I drank.	☐	☐	☐	☐	☐
22. I disappointed others when I drank.	☐	☐	☐	☐	☐
23. I felt confident when I drank.	☐	☐	☐	☐	☐
24. I used poor judgment when I drank.	☐	☐	☐	☐	☐
25. I had more fun when I drank.	☐	☐	☐	☐	☐
26. I had trouble getting things done after I drank.	☐	☐	☐	☐	☐

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 23, 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:	Never	Rarely	Often
6. To improve my appetite/gain weight	☐	☐	☐
7. Induce sleep	☐	☐	☐
8. Relieve nausea/vomiting	☐	☐	☐
9. Relieve pain	☐	☐	☐
10. Relieve anxiety/depression/stress	☐	☐	☐

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

Other Drug Use

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

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 27

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)	☐	☐	☐
3.	Any other partner who you knew (friend or acquaintance)	☐	☐	☐
4.	Any other partner whom you did not know (anonymous sex or someone you just met)	☐	☐	☐
5.	Any partner who was HIV positive	☐	☐	☐
6.	Any partner who was HIV negative	☐	☐	☐
7.	Any partner whose HIV status was unknown or you were not sure	☐	☐	☐
8.	Any partner whom you received money or drugs in exchange for sex	☐	☐	☐
9.	Any partner whom you provided money or drugs in exchange for sex	☐	☐	☐

ATTENTION:
If you currently have a penis complete this section, otherwise skip to next page, PAGE 26.

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

Sexual activity with women	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 with men	**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 27.

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

Sexual activity with men		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 with women		**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:		Never	Yes- within past 3 years	Yes- more than 3 years ago	Not Sure
1.	Mammogram (breast cancer test)	☐	☐	☐	☐
2.	Colonoscopy (colon cancer test)	☐	☐	☐	☐
3.	Pap smear (gynecology exam – cervix cancer test)	☐	☐	☐	☐
4.	Anal pap test (test for anal cancer)	☐	☐	☐	☐

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:		Never	Yes- within past 3 years	Yes- more than 3 years ago	Not Sure
5.	Prostate (prostate cancer test)	☐	☐	☐	☐
6.	Colonoscopy (colon cancer test)	☐	☐	☐	☐
7.	Anal pap test (test for anal cancer)	☐	☐	☐	☐

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 prevent transmission of their HIV virus to another person. Please check each of the strategies that YOU use to prevent transmission of HIV to your main sexual partner (in a serious relationship)?

- ☐ We don't have sex
- ☐ My partner takes PrEP
- ☐ We use condoms
- ☐ I keep my HIV virus suppressed (undetectable)
- ☐ We avoid certain kinds of sex that are more risky
- ☐ Any other method? (explain) _____
- ☐ No strategy

Casual Partners

9. People use different strategies to prevent transmission of their HIV virus to another person. Please check each of the strategies that YOU use to prevent transmission of HIV to a casual partner (not in a serious relationship)?

- ☐ I don't have any casual partners
- ☐ My partner takes PrEP
- ☐ We use condoms
- ☐ I keep my HIV virus suppressed (undetectable)
- ☐ 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 a medication used to treat HIV, but it can also be used by a person without HIV to reduce their chances of becoming HIV positive. The next set of questions are about using PrEP by someone who does not have HIV in order to prevent becoming infected.

Awareness

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

- ☐ Yes
- ☐ No SKIP TO PAGE 33

2. Where did you first hear 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)_____

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

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

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

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

- ☐ Not difficult
- ☐ Somewhat not difficult
- ☐ Neutral
- ☐ Somewhat difficult
- ☐ Difficult

6. 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

Infomation Source

7. Please select which 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)_____

8. Please select which 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)_____

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