MEDICAL HISTORY QUESTIONNAIRE

NIAID AIDS CLINICAL TRIALS GROUP

Patient Number ☐☐☐ ☐☐☐☐ ☐ Date Specimen(s) Obtained/Scheduled ☐☐☐ mmm ☐☐ dd ☐☐☐☐ yyyy

Protocol Number A 5 2 5 3 ☐ Institution Code ☐☐☐☐☐☐

Form Week ☐☐☐☐ * Seq. No. ☐☐ ** Step No. ☐☐ Key Operator Code ☐☐☐

* Enter a '1' if this is the first of this form for this date. Designate subsequent forms on the same date with a 2, 3, etc.
** Enter the subject's current study step number. Enter '1' if the study does not have multiple steps.

INSTRUCTIONS:

- Complete the questionnaire as a face-to-face interview.
- If the participant does not answer a question, use '-1' to indicate 'Not done.'.

1. Was the questionnaire conducted as a face-to-face interview? ………………… (1-Yes, 2-No) ☐
   If No, go to 'b.'
   If Yes, complete 'a.'

   a. Is the person responding to these questions someone other than the study participant? ………………………………………………………. (1-Yes, 2-No) ☐
   If No, go to question 2.
   If Yes, complete 'a1' and go to question 2.

   a1. Who is responding to the questions? …………………………………… ☐
   1-Parent
   2-Spouse or partner
   3-Friend
   4-Other relative, specify
   9-Other, specify

   If 4 or 9, specify [70]: ____

   b. Indicate the reason why:………………………..………… ☐
   1-Study participant refused
   2-There was not enough time
   9-Other reason, specify

   If 1, 2 or 3, STOP.
   If 4, go to question 2.
   If 9, complete 'b1' and STOP.

   b1. **If 9,** specify [70]: ____

2. Indicate the language used to conduct the interview [70]: ______________________________

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IDENTIFYING INFORMATION

3. What is your occupation? ……………………… ☐
   1-Skilled worker (e.g. doctor, teacher)
   2-Semi-skilled worker (e.g. clerk, salesperson)
   3-Unskilled worker (e.g. laborer, farmer, street vendor)
   4-Student or child
   9-Other, specify

   If Other, specify [70]:____

HISTORY/STATUS OF PRESENT ILLNESS

4. Are you currently hospitalized? ………………………………………………………… (1-Yes, 2-No) ☐
   If No, go to question 5.
   If Yes, continue.

   a. Date admitted to this hospital for this hospitalization (mmm/dd/yyyy): ……………………………… ☐☐☐ ☐☐ ☐☐☐☐

5. In the past 30 days, have you had a cough? …………………………… (1-Yes, 2-No, 3-Not known) ☐
   If No or Not known, go to question 6.
   If Yes, continue.

   a. How long has this cough lasted? ………………………………………………… ☐☐☐ days
      If greater than or equal to 28 days, continue.'
      If less than 28 days, go to 'b.'

      a1. Has your cough worsened in the past month? ………………… (1-Yes, 2-No, 3-Not known) ☐

   b. Are you producing sputum with this cough? ………………………… (1-Yes, 2-No, 3-Not known) ☐

   c. Have you had trouble sleeping because of the cough? …………… (1-Yes, 2-No, 3-Not known) ☐

   d. Do you cough at least once every day? ……………………………… (1-Yes, 2-No, 3-Not known) ☐

   e. Did you have a cough in the past 24 hours? ………………………… (1-Yes, 2-No, 3-Not known) ☐

6. In the past 30 days, have you had a fever? …………………………… (1-Yes, 2-No, 3-Not known) ☐
   If No or Not known, go to question 7.
   If Yes, continue.

   a. How many days has your fever lasted? ………………………………………… ☐☐☐ days

   b. Did you have a fever in the past 24 hours? ………………………… (1-Yes, 2-No, 3-Not known) ☐

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7. In the past 30 days, have you had night sweats? ……………………… (1-Yes, 2-No, 3-Not known) [ ]
   If No or Not known, go to question 8.
   If Yes, continue.
   a. How many days have you had the night sweats? ……………………………… [ ][ ][ ] days
   b. Did you have night sweats in the past 24 hours? …………………… (1-Yes, 2-No, 3-Not known) [ ]

8. In the past 30 days, have you had diarrhea (3 or more loose stools in < 24 hours)? …………………………………… (1-Yes, 2-No, 3-Not known) [ ]
   If No or Not known, go to question 9.
   If Yes, continue.
   a. How long have you had diarrhea? ……………………………………………… [ ][ ][ ] days
   b. Did you have diarrhea in the past 24 hours? ………………………… (1-Yes, 2-No, 3-Not known) [ ]

9. In the past 30 days, have you had any unintentional weight loss? …… (1-Yes, 2-No, 3-Not known) [ ]
   If No or Not known, go to question 10.
   If Yes, continue.
   a. How much weight would you estimate that you have lost in the past 30 days? [ ][ ][ ].[ ]
   b. Indicate unit of estimated weight loss: …………………………………………… 1-Pounds 2-Kilograms [ ]

In the past 30 days, have you had any of the following other symptoms?
(Answer '1-Yes,' '2-No' or '3-Not known' to each question.) (1-Yes, 2-No, 3-Not known)

10. Coughing up blood? ………………………………………………………………… [ ]
    a. **If Yes,** have you coughed up blood in the past 24 hours? …………………………… [ ]
11. Difficulty breathing? ………………………………………………………………. [ ]
    a. **If Yes,** have you had difficulty breathing in the past 24 hours? ……………………… [ ]
12. Pain or tightness in your chest? ………………………………………………………… [ ]
    a. **If Yes,** have you had pain or tightness in your chest in the past 24 hours? ………… [ ]
13. Pain in your mouth or throat? ……………………………………………………………. [ ]
    a. **If Yes,** have you had pain in your mouth or throat in the past 24 hours? …………… [ ]
14. Pain when swallowing? …………………………………………………………………… [ ]
    a. **If Yes,** have you had pain when swallowing in the past 24 hours? ………………….. [ ]

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In the past 30 days, have you had any of the following other symptoms?
(Answer '1-Yes,' '2-No' or '3-Not known' to each question.) (1-Yes, 2-No, 3-Not known)

15. Nausea or vomiting? …… ☐
    a. **If Yes,** have you had nausea or vomiting in the past 24 hours? …… ☐
16. Abdominal pain? …… ☐
    a. **If Yes,** have you had abdominal pain in the past 24 hours? …… ☐
17. Loss of appetite? …… ☐
    a. **If Yes,** have you lost your appetite in the past 24 hours? …… ☐
18. Burning when you urinate? …… ☐
    a. **If Yes,** have you had burning when you urinate in the past 24 hours? …… ☐
19. Blood in your urine? …… ☐
    a. **If Yes,** have you had blood in your urine in the past 24 hours? …… ☐
20. Sores on your penis or vagina? …… ☐
    a. **If Yes,** have you had sores on your penis or vagina in the past 24 hours? …… ☐
21. Pain, numbness, or tingling in your feet? …… ☐
    a. **If Yes,** have you had pain, numbness, or tingling in your feet in the past 24 hours? ☐
22. Itching or rash? …… ☐
    a. **If Yes,** have you had itching or a rash in the past 24 hours? …… ☐
23. Pain in your muscles, joints, or bones? …… ☐
    a. **If Yes,** have you had pain in your muscles, joints, or bones in the past 24 hours? .. ☐
24. Difficulty with vision? …… ☐
    a. **If Yes,** have you had difficulty with your vision in the past 24 hours? …… ☐
25. Headache? …… ☐
    a. **If Yes,** have you had a headache in the past 24 hours? …… ☐
26. Muscle weakness? …… ☐
    a. **If Yes,** have you had muscle weakness in the past 24 hours? …… ☐
27. Fatigue? …… ☐
    a. **If Yes,** have you been fatigued in the past 24 hours? …… ☐

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In the past 30 days, have you had any of the following other symptoms?
(Answer '1-Yes,' '2-No' or '3-Not known' to each question.) (1-Yes, 2-No, 3-Not known)

28. Difficulty sleeping? …………………………………………………………………… ☐
    a. **If Yes,** have you had difficulty sleeping in the past 24 hours? ………………………. ☐
29. Dizzy or lightheaded? ……………………………………………………………….. ☐
    a. **If Yes,** have you been dizzy or lightheaded in the past 24 hours? …………………… ☐
30. Trouble thinking or concentrating? …………………………………………………… ☐
    a. **If Yes,** have you had trouble thinking or concentrating in the past 24 hours? ……… ☐
31. Feeling depressed or sad? ……………………………………………………………. ☐
    a. **If Yes,** have you felt depressed or sad in the past 24 hours? ………………………… ☐
32. Shaking chills? ………………………………………………………………………. ☐
    a. **If Yes,** have you had shaking chills in the past 24 hours? …………………………… ☐
33. Decreased hearing? …………………………………………………………………… ☐
    a. **If Yes,** have you had decreased hearing in the past 24 hours? …………………….. ☐

34. Do you currently have any of the above symptoms (questions 10-33)? (1-Yes, 2-No, 3-Not known) ☐
    If No or Not known, go to question 35.
    If Yes, continue.

    a. On a scale of 1-10, how severe are the symptoms you have right now?
       "1" means that your symptoms do not bother you at all.
       "10" means that they are very bad. ……………………………………………………… ☐☐

    b. How long have your most annoying symptoms been at this level? ……………… ☐☐ days

    c. Of the above symptoms (questions 10-33), which is your most annoying symptom?
       (Record the number from 10-33 corresponding to the single most annoying symptom.) ☐☐

    d. Specify the most annoying symptom [70]:

    ____

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HIV TRANSMISSION RISK FACTORS

Answer '1-Yes,' '2-No,' '3-Not known' to each question. 1-Yes, 2-No, 3-Not known

35. Have you ever had sexual intercourse with a woman? ………………………………… ☐
36. Have you ever had sexual intercourse with a man? …………………………………… ☐
37. Have you ever had sexual intercourse with a sex worker? ………………………….. ☐
38. Have you ever received money, gifts or favors for sex? …………………………… ☐
39. Have you ever injected a drug into yourself? ……………………………………….. ☐
40. Have you ever received a blood transfusion? ………………………………………. ☐
41. Do you currently have a partner with whom you have sexual intercourse? ……… ☐
    If Yes, does he/she have HIV? …………………………………………………….. ☐
42. Does/did your mother or father have HIV? …………………………………………… ☐

CHEST INFECTION/TUBERCULOSIS HISTORY

Answer '1-Yes,' '2-No,' '3-Not known' to each question. 1-Yes, 2-No, 3-Not known

43. Have you bee treated for any chest infections in the past year? ………………………… ☐
44. Have you ever been treated for TB disease for more than 30 days? …………………… ☐
    If Yes, was this within the past year? ………………………………………………………. ☐
45. Have you ever been given medications to prevent TB? ………………………………….. ☐
    If Yes, was this within the past year? ………………………………………………………. ☐
46. Has anyone living in your home received TB treatment in the past 2 years? …………… ☐
    If Yes, is that person currently receiving TB treatment? ………………………………… ☐
47. Do you know anyone living outside your home who has received TB treatment in the past 2 years? ……………………………………………………………………… ☐
    If Yes, is that person currently receiving TB treatment? ………………………………… ☐

48. Do you have any further pertinent comments about your medical history? …… (1-Yes, 2-No) ☐
    If No, STOP.
    If Yes, continue.

    a. Comments [70]: ____

Date Form Keyed (DO NOT KEY): _______ / _______ / _______