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**LONGITUDINAL STUDIES OF HIV-ASSOCIATED
LUNG INFECTIONS & COMPLICATIONS (LUNG-HIV)**

PULMONARY HIV QUESTIONNAIRE

I. HOW IS THE QUESTIONNAIRE BEING ADMINISTERED?

- | | |
|-------------------------------|-----|
| Interviewer | (1) |
| Patient completed on computer | (2) |
| Patient completed on paper | (3) |

II. HAART REGIMEN

HAART (Highly Active Antiretroviral Therapy) is defined as three or more drugs, including one highly-active compound.

- | | Yes | No | Unknown |
|--|-----|-----|---------|
| A. Before entering this study, had you ever been on a HAART regimen? <i>(Please ask this question only at the baseline study visit.)</i> | (1) | (2) | (3) |
| B. Are you currently on a HAART regimen? | (1) | (2) | (3) |

If B is 'Yes', skip to Section III.

- | | | | |
|---|-----|-----|-----|
| a. Have you been on a HAART regimen in the last six months? | (1) | (2) | (3) |
|---|-----|-----|-----|

III. RESPIRATORY SYMPTOMS

The following questions are about respiratory or chest symptoms. If you are in doubt whether the answer is 'Yes' or 'No', please answer 'No'.

A. COUGH

- | | | |
|--|------------|-----------|
| 1. Do you usually have a cough (exclude clearing of throat)? | Yes
(1) | No
(2) |
|--|------------|-----------|

If 1 is 'No', skip to 2.

- | | | |
|---|-----|-----|
| a. Do you usually cough as much as four times a day, four or more days out of a week? | (1) | (2) |
| 2. Do you usually cough at all on getting up or first thing in the morning? | (1) | (2) |
| 3. Do you usually cough at all during the rest of the day or at night? | (1) | (2) |

If 'Yes' to any in A, answer the following. OTHERWISE skip to B.

- | | | |
|--|-----|-------------|
| 4. Do you usually cough like this on most days for three consecutive months or more during the year? | (1) | (2) |
| 5. For how many years have you had this cough? | | _____ years |

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B. PHLEGM

- | | | |
|--|------------|-----------|
| 1. Do you usually bring up phlegm from your chest? | Yes
(1) | No
(2) |
|--|------------|-----------|

If 1 is 'No', skip to 3.

- | | | |
|---|------------|-----------|
| 2. Do you usually bring up phlegm like this as much as twice a day four or more days out of the week? | Yes
(1) | No
(2) |
| 3. Do you usually bring up phlegm from your chest on getting up or first thing in the morning? | (1) | (2) |
| 4. Do you usually bring up phlegm from your chest during the rest of the day or at night? | (1) | (2) |

If 'Yes' to any in B, answer the following. OTHERWISE skip to C.

- | | | |
|--|-------------|-----|
| 5. Do you bring up phlegm like this on most days for three consecutive months or more during the year? | (1) | (2) |
| 6. For how many years have you had trouble with phlegm? | _____ years | |

C. WHEEZING

- | | | | |
|---|-----|-----|------------|
| | Yes | No | Don't Know |
| 1. Have you ever had an attack of wheezing or whistling in your chest that made you feel short of breath? | (1) | (2) | (3) |

If 1 is 'No' or 'Don't Know', skip to 4.

- | | | | |
|---|-----|-----|-----|
| 2. Have you ever had two or more such attacks? | (1) | (2) | (3) |
| 3. Have you ever required medicine or treatment for such attacks? | (1) | (2) | (3) |
| 4. In the last 12 months, have you had wheezing or whistling in your chest at any time? | (1) | (2) | |

If 4 is 'No', skip to D.

- | | | |
|---|-----|-----|
| 5. In the last 12 months, does your chest ever sound wheezy or whistling: | Yes | No |
| a. When you have a cold? | (1) | (2) |
| b. Occasionally apart from colds? | (1) | (2) |
| c. More than once a week? | (1) | (2) |
| d. Most days and nights? | (1) | (2) |

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D. SHORTNESS OF BREATH

- | | | |
|---|-----|-----|
| | Yes | No |
| 1. Are you unable to walk due to a condition other than shortness of breath? | (1) | (2) |
| 2. Are you troubled by shortness of breath when hurrying on level ground or walking up a slight hill? | (1) | (2) |

If 2 is 'No', skip to Section IV.

- | | Yes | No | Does Not Apply |
|--|-----|-------|----------------|
| a. Do you have to walk slower than people of your age on level ground because of shortness of breath? | (1) | (2) | (3) |
| b. Do you ever have to stop for breath when walking at your own pace on level ground? | (1) | (2) | (3) |
| c. Do you ever have to stop for breath after walking about 100 yards (or after a few minutes) on level ground? | (1) | (2) | (3) |
| d. Are you too short of breath to leave the house or short of breath on dressing or undressing? | (1) | (2) | (3) |
| e. For how many years have you had shortness of breath? | | _____ | _____ |
| | | years | |

IV. SOURCE OF INFECTION

- | | | |
|--|---------------------------|-----|
| A. Are you infected with HIV? | Yes | No |
| | (1) | (2) |
|
 | | |
| B. If yes, how did you acquire HIV infection? | (Choose only one.) | |
| Male-to-male sexual contact | (1) | |
| Injection drug use | (2) | |
| Male-to-male sexual contact and injection drug use | (3) | |
| Heterosexual contact | (4) | |
| Other ** | (5) | |
| B1. specify: _____ | | |
| Unknown | (6) | |

** Includes "hemophilia, blood transfusion, perinatal exposure, and risk factor not reported or not identified."

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V. HISTORY OF LUNG DISEASES

A. ASTHMA

1. Has a doctor or health care provider **EVER** told you that you had asthma?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |

If 1 is 'No', skip to B.

2. How old were you when your doctor **FIRST** told you that you had asthma?
- | | |
|---------------|--------------|
| Age, in years | _____ |
| | <i>years</i> |
| don't know | (1) |
| refused | (2) |
3. Do you still have it?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
4. In the **LAST 6 MONTHS**, have you taken medicines or used an inhaler for asthma?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |

B. COPD, EMPHYSEMA, AND CHRONIC BRONCHITIS

1. Has a doctor or health care provider **EVER** told you that you had chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |

If 1 is 'No', skip to C.

2. How old were you when you were **FIRST** told that you had COPD, emphysema or chronic bronchitis?
- | | |
|---------------|--------------|
| Age, in years | _____ |
| | <i>years</i> |
| don't know | (1) |
| refused | (2) |

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3. Have you ever taken medicine or used an inhaler for COPD, emphysema, or chronic bronchitis?

- Yes (1)
No (2)
don't know (3)

If 3 is, 'No', skip to C.

4. In the **LAST 6 MONTHS**, have you taken medicines or used an inhaler for COPD, emphysema, or chronic bronchitis?

- Yes (1)
No (2)
don't know (3)
refused (7)

C. OTHER LUNG DISEASES

1. Has a doctor or health care provider ever told you that you had lung cancer?

- Yes (1)
No (2)
don't know (3)
refused (7)

If 1 is 'No', skip to 3.

2. How old were you when you were first told you had lung cancer?

- Age, in years _____
years
don't know (1)
refused (2)

3. Has a doctor or health care provider ever told you that you had sarcoidosis?

- Yes (1)
No (2)
don't know (3)
refused (7)

If 3 is 'No', skip to 5.

4. How old were you when you were first told you had sarcoidosis?

- Age, in years _____
years
don't know (3)
refused (7)

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5. Has a doctor or health care provider ever told you that you had sleep apnea?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |

If 5 is 'No', skip to 7.

6. How old were you when you were first told you had sleep apnea?
- | | | |
|---------------|-----|-------|
| Age, in years | — — | years |
| don't know | (1) | |
| refused | (2) | |
7. Has a doctor or health care provider ever told you that you had pulmonary hypertension or high blood pressure in your lungs?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |
8. Has a doctor or health care provider ever told you that you had Tuberculosis (TB)?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |
9. Has a doctor or health care provider ever told you that you had Pneumocystis pneumonia (PCP)?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |
10. Has a doctor or health care provider ever told you that you had other pneumonia or bronchopneumonia?
- | | |
|------------|-----|
| Yes | (1) |
| No | (2) |
| don't know | (3) |
| refused | (7) |
11. Have you ever had any chest operations?
- | | |
|-----|-----|
| Yes | (1) |
| No | (2) |

If 11 is 'No', skip to Section VI.

11.a. If 'Yes', specify: _____

ID Number: - -

VI. SMOKING HISTORY

**SECTIONS A AND B ARE SITE-SPECIFIC.
 PLEASE CHOOSE WHICH SECTION APPLIES TO YOUR SITE.**

A. CIGARETTE SMOKING (Detailed)

1. Have you smoked at least 100 cigarettes in your entire life?
- Yes (1)
 No (2)

If 1 is 'No', skip to C.

2. How old were you when you first started to smoke fairly regularly?

 years
3. On average for the **ENTIRE TIME** you smoked, how many cigarettes did you smoke per day?

 cigarettes
4. Do you now smoke cigarettes? **(Choose only one.)**
- Every day (1)
 Some days **(Skip to A.6)** (2)
 Not at all **(Skip to A.8)** (3)
5. On average, how many cigarettes do you now smoke a day?

 cigarettes
- don't know (1)
6. During the **PAST 30 DAYS**, on how many days did you smoke a cigarette?

 days
- don't know (1)
7. During the **PAST 30 DAYS**, on the days that you smoked, how many cigarettes did you smoke per day?

 cigarettes
- don't know (1)
8. How old were you when you last smoked cigarettes fairly regularly?

 years
9. For how many years in total did you quit smoking?
 _____ . _____
 years

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10. If not smoking:
- a. How long has it been since you last smoked cigarettes regularly?
- | | |
|----------------------|-----|
| Still smoking | (1) |
| Less than 6 months | (2) |
| 6 – 12 months | (3) |
| More than 1 year ago | (4) |
- b. If you stopped smoking regularly more than 1 year ago, please tell us how many years ago you quit. _____
years

B. CIGARETTE SMOKING (Brief)

1. Have you smoked at least 100 cigarettes in your entire life?
- | | |
|-----|-----|
| Yes | (1) |
| No | (2) |

If 1 is 'No', skip to C.

2. How old were you when you first started to smoke fairly regularly? _____
years
3. On average, how many cigarettes do you now smoke a day? _____
per day
4. On average, for the **ENTIRE TIME** you smoked, how many cigarettes did you smoke a day? _____
per day
5. For how many years in total did you quit smoking? _____ . _____
years

C. CIGAR AND PIPE SMOKING

- | | | |
|---|-----|-----|
| | Yes | No |
| 1. Have you smoked a cigar at least 20 times in your entire life? | (1) | (2) |

If 1 is 'No', skip to 2.

- | | | |
|--|-----|-----|
| | Yes | No |
| 1a. Do you now smoke cigars regularly? | (1) | (2) |
| 2. Have you smoked a pipe at least 20 times in your entire life? | (1) | (2) |

If 2 is 'No', skip to D.

- | | | |
|--|-----|-----|
| | Yes | No |
| 2a. Do you now smoke a pipe regularly? | (1) | (2) |

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D. SECOND HAND SMOKE EXPOSURE

- | | Yes | No |
|--|-------|-------|
| 1. Before age 13, did you live with a regular cigarette smoker who smoked in your home? | (1) | (2) |
| 2. Since age 13, have you ever lived with a regular cigarette smoker (not including yourself) who smoked in your home? | (1) | (2) |
| 3. Since age 13, when not home, have you ever spent time regularly indoors where there are people smoking cigarettes? | (1) | (2) |

If you are a non-smoker, skip to Section VII.

E. QUIT ATTEMPTS (Detailed)

1. During the **PAST 12 MONTHS**, have you stopped smoking for more than one day **BECAUSE YOU WERE TRYING TO QUIT SMOKING?**
- | | |
|------------|-------|
| Yes | (1) |
| No | (2) |
| don't know | (3) |

If 1 is 'No', 'Don't Know' or 'Does Not Apply', skip to G.

2. In the past 12 months, did you use any of the following products to help you quit? **(Check all that apply.)** Yes
- | | |
|------------------------------------|-------|
| a. Nicotine patches | (1) |
| b. Nicotine gum | (1) |
| c. Nicotine lozenges | (1) |
| d. Nicotine inhaler | (1) |
| e. Nicotine nasal spray | (1) |
| f. Zyban (Wellbutrin or bupropion) | (1) |
| g. Chantix (varenicline) | (1) |
| h. Other medications | (1) |
| ha. specify: _____ | |
| i. I did not use any medications. | (1) |
3. In the past 12 months, did you use any of the following to help you quit? **(Check all that apply.)** Yes
- | | |
|---|-------|
| a. Talked with your own doctor or nurse about quitting | (1) |
| b. One-on-one counseling from doctor, nurse, or other health professional | (1) |
| c. Stop smoking clinic or class/group | (1) |
| d. Telephone helpline | (1) |
| e. Book, pamphlet, video, or audio tape | (1) |
| f. Online or web-based counseling services | (1) |
| g. Alternative techniques:
(hypnosis, acupuncture, biofeedback, herbal remedy, etc.) | (1) |
| h. Tapering down | (1) |

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- i. Other program or service (1)
 ia. *specify:* _____
- j. I did not use any programs or services (1)

F. QUIT ATTEMPTS (Brief)

- | | Yes | No | Don't Know |
|--|-----|-----|------------|
| 1. During the PAST 12 MONTHS , have you stopped smoking for more than one day BECAUSE YOU WERE TRYING TO QUIT SMOKING? | (1) | (2) | (3) |

<i>If 1 is 'No', skip to G.</i>
--

- | | |
|--|-----|
| 2. In the past 12 months, did you use any of the following products to help you quit? (Check all that apply.) | Yes |
| a. Nicotine patches | (1) |
| b. Nicotine gum | (1) |
| c. Nicotine lozenges | (1) |
| d. Nicotine inhaler | (1) |
| e. Nicotine nasal spray | (1) |
| f. Zyban (Wellbutrin or bupropion) | (1) |
| g. Chantix (varenicline) | (1) |
| h. Other medications | (1) |
| ha. <i>specify:</i> _____ | |
| i. I did not use any medications. | (1) |

G. Fagerstrom Test of Nicotine Dependence (FTND)

<i>This section of questions asks about your smoking behavior. Don't worry if you are not sure about an answer... we are simply interested in finding out what you think.</i>
--

- | | | |
|---|-----|-----|
| 1. How soon after you wake up do you smoke your first cigarette? | | |
| Within 5 minutes | (1) | |
| 6-30 minutes | (2) | |
| 31-60 minutes | (3) | |
| After 60 minutes | (4) | |
| 2. Do you find it difficult to keep from smoking in places where it is not allowed, like in church, at the library, at the movies, in the hospital, etc.? | Yes | No |
| | (1) | (2) |
| 3. Which cigarette would you hate most to give up? | | |
| The first one in the morning | (1) | |
| All the others | (2) | |

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- | | Yes | No |
|--|-----|-----|
| 4. Do you smoke more frequently during the first hours after waking than during the rest of the day? | (1) | (2) |
| 5. Do you smoke if you are so sick that you are in bed most of the day? | (1) | (2) |

VII. ALCOHOL USE

- | | Yes | No |
|--|-----|-----|
| A. Have you ever had a drink containing alcohol? | (1) | (2) |

<i>If A is 'No', skip to Section VIII.</i>

- | | Yes | No |
|--|-----|-----|
| B. In the LAST 12 MONTHS , have you had a drink containing alcohol? | (1) | (2) |

<i>If B is 'No', skip to F.</i>
--

Note: 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). Items 3-5 refer to the last 12 months.

- | | | |
|---|------------|-----------|
| C. How often do you have a drink containing alcohol? | | |
| Never (Skip to F.) | (1) | |
| 2 – 3 times per week | (2) | |
| Monthly or less | (3) | |
| 4 or more times per week | (4) | |
| 2 – 4 times per month | (5) | |
| D. How many drinks containing alcohol do you have on a typical day when you are drinking? | | |
| 1 or 2 | (1) | |
| 3 or 4 | (2) | |
| 5 or 6 | (3) | |
| 7 to 9 | (4) | |
| 10 or more | (5) | |
| E. How often do you have six or more drinks on one occasion? | | |
| Never | (1) | |
| Daily or almost daily | (2) | |
| Weekly | (3) | |
| Less than monthly | (4) | |
| Monthly | (5) | |
| F. During your lifetime, have you regularly drunk alcohol, that is beer, wine, a mixed drink or any other kind of alcoholic beverage? | Yes
(1) | No
(2) |

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We are asking you to take part in a research study that involves your lungs and HIV. We want to learn more about any experience you may have with recreational drugs. This questionnaire will be asking you about your past and current recreational drug use. If you decide to take part, we will proceed with the questions listed on this form.

Do you agree to participate in answering a few personal questions regarding your recreational drug use? Yes (1) No (2)

If 'No', skip to Section IX.

VIII. RECREATIONAL DRUG USE HISTORY

A. Have you **ever** smoked or snorted any drug(s)? Yes (1) No (2) refused (7)

If 'No', skip to B.

	(a)	(b)	(c)	(d)
	Have you ever smoked or snorted [drug]?	How old were you when you first took this type of drug?	On average, how often would you use this type of drug?	How long has it been since you last used this type of drug?
1. Marijuana (hash)	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (7)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
2. Crack/ready rock or freebase cocaine (smoked)	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (7)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)

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(a) Have you ever smoked or snorted [drug]?		(b) How old were you when you first took this type of drug?	(c) On average, how often would you use this type of drug?	(d) How long has it been since you last used this type of drug?
3.	Cocaine by snorting Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
4.	Heroin by snorting Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
5.	Crystal methamphetamine by snorting or smoking Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)

B. Have you **ever** injected any drug(s)? Yes (1) No (2) Refused (7)

If 'No', skip to C.

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(a) Have you ever injected [drug]?			(b) How old were you when you first took this type of drug?	(c) On average, how often would you use this type of drug?	(d) How long has it been since you last used this type of drug?
1.	Cocaine by injection	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
2.	Cocaine and heroin together (speedball) by injection	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
3.	Heroin by injection (by itself)	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
4.	Crystal methamphetamine by injection	Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)

ID Number: - -

(a) Have you ever injected [drug]?	(b) How old were you when you first took this type of drug?	(c) On average, how often would you use this type of drug?	(d) How long has it been since you last used this type of drug?
5. Other amphetamine by injection Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)

C. Have you **ever** ingested any drug(s)? Yes (1) No (2) Refused (7)

If 'No', skip to Section IX.

(a) Have you ever ingested [drug]?	(b) How old were you when you first took this type of drug?	(c) On average, how often would you use this type of drug?	(d) How long has it been since you last used this type of drug?
1. Marijuana (hash) Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
2. Street methadone or Buprenorphine purchased on the street taken orally not from a program Yes (1) No (2) refused (7)	— —	Several times per day (1) Once per day, every day (2) More than once per week, but less than once per day (3) Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
3. Prescription Yes (1)		Several times per day (1)	Within the past 30 days (1)

ID Number: - -

(a) Have you ever ingested [drug]?	(b) How old were you when you first took this type of drug?	(c) On average, how often would you use this type of drug?	(d) How long has it been since you last used this type of drug?
opiates No (2) (Oxycontin, refused (7) Percocet) purchased on the street taken orally	____ ____	Once per day, every day (2) More than once per (3) week, but less than once per day Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)
4. Methampheta- Yes (1) mine or other No (2) amphetamines refused (7) taken orally	____ ____	Several times per day (1) Once per day, every day (2) More than once per (3) week, but less than once per day Once per week (4) 2 – 3 times per month (5) Once per month (6) Several times per year (7) Once per year (8) refused (77)	Within the past 30 days (1) More than 30 days ago but within last 12 months (2) More than 12 months ago (3) refused (7)

IX. DOMESTIC AND OCCUPATIONAL EXPOSURE

A. BRIEF

	Yes	No
1. During the last 12 months, have you burned wood or coal for heating your home or for cooking?	(1)	(2)
2. During the last 12 months, has there been any flooding or water damage in your house?	(1)	(2)
3. During the last 12 months, have you noted any mold or mildew on any surface, other than food, inside your home?	(1)	(2)
4. In the last 12 months, have you had any of the following pets living in your home?		
a. Cat	(1)	(2)
b. Dog	(1)	(2)
c. Other furry pets	(1)	(2)
d. Birds	(1)	(2)

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5. During the last 12 months, have you noticed any of the following pests in your home?
- | | | |
|----------------|-----|-----|
| a. Cockroaches | (1) | (2) |
| b. Mice / Rats | (1) | (2) |
6. Have you ever been exposed at work or in your hobbies to vapors, gas, dust or fumes? (1) (2)

B. OCCUPATIONAL EXPOSURE (DETAILED)

In addition to section A above, please answer the question below

1. In any of your jobs or hobbies, did you come into regular contact with any vapors, gases, dusts or fumes? Yes (1) No (2)

If 1 is 'No', skip to Section X.

2. Have you come into regular contact with any of the following **specific vapors, gases, dusts, or fumes?** (i.)
 (If exposure was for less than one year, enter '0' and count reply as 'No'.)
- | | Yes | No | don't know | Number of years |
|--|-----|-----|------------|-----------------|
| a. Irritant gases, such as chlorine or ammonia | (1) | (2) | (3) | ____ |
| b. Fire, smoke or other combustion products | (1) | (2) | (3) | ____ |
| c. Incinerators, boilers or oil refineries | (1) | (2) | (3) | ____ |
| d. Coal dust or powder | (1) | (2) | (3) | ____ |
| e. Silica or sand, or concrete or cement dust | (1) | (2) | (3) | ____ |
| f. Indoor fuel powered motors, compressors, or engines | (1) | (2) | (3) | ____ |
| g. Diesel engine exhaust | (1) | (2) | (3) | ____ |
| h. Wheat flour or other grain dusts | (1) | (2) | (3) | ____ |
| i. Animal feeds or fodder | (1) | (2) | (3) | ____ |
| j. Cotton dust or cotton processing | (1) | (2) | (3) | ____ |
| k. Wood dust or saw dust | (1) | (2) | (3) | ____ |
| l. Cadmium fumes or batteries or silver solder | (1) | (2) | (3) | ____ |
| m. Other metal dusts or metal fumes | (1) | (2) | (3) | ____ |
| n. Welding or flame cutting | (1) | (2) | (3) | ____ |
| o. Fiberglass, asbestos, or other man-made fibers | (1) | (2) | (3) | ____ |
| p. Explosives or blasting fumes | (1) | (2) | (3) | ____ |
| q. Other | (1) | (2) | (3) | ____ |
| qa. specify: _____ | | | | |

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X. FAMILY HISTORY

- A. Were either of your natural (biologic) parents ever told by a doctor or other health professional that they had any of the following conditions?
- | | Yes | No | don't know |
|---|-----|-----|------------|
| 1. Chronic Obstructive Pulmonary Disease (COPD) | (1) | (2) | (3) |
| 2. Asthma | (1) | (2) | (3) |
| 3. Lung Cancer | (1) | (2) | (3) |
| 4. Other Lung Diseases | (1) | (2) | (3) |
| 4a. <i>specify:</i> | | | |
-

XI. SF-8™ HEALTH SURVEY

This survey asks for your views about your health. This information will help you keep track of how you feel and how well you are able to do your usual activities. Thank you for completing this survey!

Answer each question by selecting the answer as indicated. If you are unsure about how to answer a question, please give the best answer you can.

For each of the following questions, please mark an (x) in the box that best describes your answer.

- A. Overall, how would you rate your health during the **PAST FOUR WEEKS**?

(1)	(2)	(3)	(4)	(5)	(6)
Excellent	Very good	Good	Fair	Poor	Very poor

- B. During the **PAST FOUR WEEKS**, how much did physical health problems limit your usual physical activities (such as walking or climbing stairs)?

(1)	(2)	(3)	(4)	(5)
Not at all	Very little	Somewhat	Quite a lot	Could not do physical activities

- C. During the **PAST FOUR WEEKS**, how much difficulty did you have doing your daily work, both at home and away from home, because of your physical health?

(1)	(2)	(3)	(4)	(5)
None at all	A little bit	Some	Quite a lot	Could not do daily work

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D. How much bodily pain have you had during the **PAST FOUR WEEKS**?

- | | | | | | |
|------|-----------|------|----------|--------|-------------|
| (1) | (2) | (3) | (4) | (5) | (6) |
| None | Very mild | Mild | Moderate | Severe | Very Severe |

E. During the **PAST FOUR WEEKS**, how much energy did you have?

- | | | | | |
|-----------|-------------|------|----------|------|
| (1) | (2) | (3) | (4) | (5) |
| Very much | Quite a lot | Some | A little | None |

F. During the **PAST FOUR WEEKS**, how much did your physical health or emotional problems limit your usual social activities with family or friends?

- | | | | | |
|------------|-------------|----------|-------------|--------------------------------|
| (1) | (2) | (3) | (4) | (5) |
| Not at all | Very little | Somewhat | Quite a lot | Could not do social activities |

G. During the **PAST FOUR WEEKS**, how much have you been bothered by **emotional problems** (such as feeling anxious, depressed or irritable)?

- | | | | | |
|------------|----------|------------|-------------|-----------|
| (1) | (2) | (3) | (4) | (5) |
| Not at all | Slightly | Moderately | Quite a lot | Extremely |

H. During the **PAST FOUR WEEKS**, how much did personal or emotional problems keep you from doing your usual work, school or other daily activities?

- | | | | | |
|------------|-------------|----------|-------------|-------------------------------|
| (1) | (2) | (3) | (4) | (5) |
| Not at all | Very little | Somewhat | Quite a lot | Could not do daily activities |

Thank you for completing these questions!

XII. ADMINISTRATIVE MATTERS

A. General Comments: _____

B. Form completed by: _____
signature

C. Date form completed: _____ - _____ - 2 0 _____
mmm dd yyyy

D. Lung HIV Staff No.: _____ - _____