

VACS PROVIDER QUESTIONNAIRE

ID Clinic

Year One Follow Up Survey



All of the following questions refer to the patient listed below. Please answer the questions to the best of your ability based on what you know about the patient. Please make your best guess. Please do not ask the patient or consult their medical records. (We are asking the patient some of these questions as well.)

When finished, please return this form to the Research Coordinator who gave it to you. This cover page and the patient identifiers will be destroyed.

Thank you for participating.

Study ID:

Last Name:

First Name:

SSN:

DOB / /
 Month: Day: Year:

PROVIDER QUESTIONNAIRE: ID

Year One Follow Up

Date Form Completed:

 / /

Provider ID:

Study ID:

1. Are you designated as the primary care provider for this patient? YES NO

2. Do you consider yourself primarily responsible for this patient? YES NO

3. How long have you been this patient's provider?

< 3 MOS. 3 - 6 MOS. 6 - 12 MOS. 1 - 2 YRS. 2 - 3 YRS. > 3 YRS.

4. Do you like working with this patient? NOT AT ALL VERY MUCH

5. How close is your relationship with this patient?

VERY CLOSE SOMEWHAT CLOSE NOT CLOSE AT ALL

6. How sick is this patient?

NEAR DEATH VERY SICK MODERATELY SICK SOMEWHAT SICK NOT SICK AT ALL

7. In your best judgment, please estimate the percentage probability that this patient will be alive in 10 years.

 %

8a. Does this patient take antiretroviral medications to treat their HIV? YES NO If no, skip to question 9.

8b. In your best judgment, please estimate the percentage probability that this patient is currently taking > 90% of their HIV antiretroviral medications? %

8c. Over the past 3 months, how often has this patient failed to take their HIV antiretroviral medications?

NEVER SOME OF THE TIME HALF OF THE TIME MOST OF THE TIME ALL THE TIME

9. Please mark the following behaviors this patient practices:

	<u>Past</u>	<u>Present</u>	<u>Never</u>	<u>Don't Know</u>
Smokes cigarettes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinks alcohol	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Drinks alcohol despite harm	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Uses illegal drugs	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

10. Does this patient have cognitive impairments or dementia?

A GREAT DEAL SOME SLIGHT NONE

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11. Please mark the following comorbid conditions this patient has ever had (to the best of your knowledge).

<u>Psychiatric Comorbid Conditions</u>	Yes	No	Don't Know
a. Anxiety	0	0	0
b. Depression	0	0	0
c. Post Traumatic Stress Disorder (PTSD)	0	0	0
d. Schizophrenia	0	0	0

<u>General Comorbid Conditions</u>	Yes	No	Don't Know
e. Alzheimer's Disease or other Dementia	0	0	0
f. Angina or CAD	0	0	0
g. Chronic Pulmonary Disease (COPD/Asthma)	0	0	0
h. Congestive Heart Failure	0	0	0
i. Myocardial Infarction	0	0	0
j. Peripheral Vascular Disease	0	0	0
k. Stroke/TIA	0	0	0

<u>HIV Comorbid Conditions</u>	Yes	No	Don't Know
l. CMV Retinitis/Disseminated	0	0	0
m. CNS Toxoplasmosis	0	0	0
n. Cryptosporidiosis	0	0	0
o. Extrapulmonary Histoplasmosis	0	0	0
p. Extrapulmonary Coccidioidomycosis	0	0	0
q. Extrapulmonary Cryptococcosis	0	0	0
r. HIV Dementia	0	0	0
s. HIV Wasting	0	0	0
t. Isosporiasis	0	0	0
u. KS	0	0	0
v. Lymphoma (non Hodgkins)	0	0	0
w. MAI or MAC	0	0	0
x. PCP	0	0	0
y. Salmonella Septicemia	0	0	0
z. Thrush/Esophageal Candidiasis	0	0	0

Other

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