

PROVIDER QUESTIONNAIRE: ID

Follow Up Two

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. To your knowledge, has this patient had vaginal or anal sex in the last 12 months?

YES (go to #8B) NO (skip to #9) DON'T KNOW (skip to #9)

8B. If yes, did the patient use a condom?

NO YES, SOMETIMES NO, BUT SEX WITH ONLY 1 PARTNER YES, ALWAYS DON'T KNOW

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"/>
Uses IV 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

