MATERNAL BEHAVIORAL SELF REPORT

NIAID AIDS CLINICAL TRIALS GROUP

Patient Number ☐☐ ☐☐☐☐ ☐ Date of Patient Visit ☐☐☐ ☐☐ ☐☐☐☐
mmm dd yyyy

Protocol Number ☐☐☐☐☐☐ 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.

FOR OFFICE USE ONLY - TEAR OFF SHEET

INSTRUCTIONS TO THE STUDY NURSE:

The MATERNAL BEHAVIORAL SELF REPORT is confidential and should be given to the subject prior to the clinical exam and preferably in a quiet, secluded area (e.g., exam room or other office). The subject must be able to read at the sixth-grade level at a minimum to complete the questionnaire without additional assistance. A member of the clinic staff may assist the subject in reading the questionnaire, if the subject requests help, but must not record the answers.

It is important to be familiar with the content and format of the questionnaire before giving it to study subjects.

At the first visit, please begin by telling the subject:

- The purpose of this form is to learn how things might affect your ability to take medicine or not.
- Please answer all questions honestly; you will not be "judged" based on your responses.
- If you do not wish to answer a question, please draw a line through it.
- Please feel free to ask if you need any of the questions explained to you.

You should then briefly go over the format of the questions and how to complete them. The questionnaire should take about 10 - 15 minutes to complete, but the subject should feel free to take all the time they need. Before giving the subject the questionnaire, please fill out the header.

Each question is in the same general format and contains several items. Note that the subject is always asked to make a "✓" next to the appropriate category.

If the subject is participating in more than one AACTG/PACTG study where this form is required when the visits coincide, complete the co-enrolled study information located on page 2. Identify both the protocol number and the appropriate form week for each protocol in which the subject is participating. Complete and key page 1 for each co-enrolled study.

Labels have been provided for use in mailing the completed confidential questionnaire to the ACTG Data Management Center. Affix a label to an envelope and instruct the subject to place the completed questionnaire in the envelope, seal it and return it to you. Mail the sealed envelope to the ACTG Data Management Center:

ACTG DATA
FSTRF
4033 Maple Road
Amherst, New York 14226

1. Was the questionnaire given to the subject? ..... (1-Yes, 2-No) ☐
   If No, complete 'a' and STOP

   a. Specify reason: ..... ☐
   1-Subject declined
   2-Not enough time to complete form in clinic
   9-Other, specify

   If Other, specify [30]: _____

2. Was the sealed envelope returned to you for mailing? ..... (1-Yes, 2-No) ☐

MATERNAL BEHAVIORAL SELF REPORT

NIAID AIDS CLINICAL TRIALS GROUP

Patient Number [ ][ ] [ ][ ][ ][ ] [ ] Date of Patient Visit [ ][ ][ ] mmm [ ][ ] dd [ ][ ][ ][ ] yyyy

Protocol Number A 0 0 0 0 [ ] Institution Code [ ][ ][ ][ ][ ][ ]

Form Week [ ][ ][ ] * Seq. No. [ ] ** Step No. [ ] Key Operator Code [ ][ ][ ]

Co-enrolled Study Information:

DO NOT KEY.

1. Study/Week [ ] 2. Study/Week [ ] 3. Study/Week [ ] 4. Study/Week [ ]

People have various health habits. The following questions ask about your alcohol and drug use, past and current.

1. Since the last visit, how often have you had a drink containing alcohol - a can or glass of beer, a glass of wine, a shot of liquor or a mixed drink with a shot of liquor, or any other kind of alcoholic beverage?

(Check one)

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month	Never
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

If Never, skip ahead to question 4.

2. Since the last visit, how many drinks did you usually have on a day when you drank any alcoholic beverages? By a drink, we mean a can or glass of beer, glass of wine, a shot of liquor, or a mixed drink with a shot of liquor or any other kind of alcoholic beverage.

(Check one)

12 or More Drinks Per Day	9 - 11 Drinks Per Day	7 or 8 Drinks Per Day	5 or 6 Drinks Per Day	3 or 4 Drinks Per Day	1 or 2 Drinks Per Day
☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

3. Since the last visit, how often have you had 5 or more alcoholic beverages in a row or within a few hours?

(Check one)

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month	Never
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

4 Have you smoked any cigarettes since the last visit?..... ☐ Yes 1 ☐ No 2

If No, go to question 5.
If Yes, complete 'a'.

a. What is the average number of packs per day that you smoke:

None	Less than ½ pack	½ pack to 1 pack	Greater than 1 pack
☐ 0	☐ 1	☐ 2	☐ 3

Pt. No. ☐☐ ☐☐☐☐ ☐ * Seq. No. ☐ ** Step No. ☐ Date ☐☐☐ ☐☐ ☐☐☐☐
mmm dd yyyy

5. Please check "Yes" or "No" for each question:

a. Have you used marijuana/hash/THC since the last visit?..... ☐ Yes (1) ☐ No (2)
If No, skip to question 5b.

If you used this drug, how often? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

b. Have you used cocaine (powder, crack, freebase) since the last visit? ... ☐ Yes (1) ☐ No (2)
If No, skip to question 5c.

If you used this drug, how often? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

c. Have you used heroin since the last visit?..... ☐ Yes (1) ☐ No (2)
If No, skip to question 5d.

If you used this drug, how often? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

d. Have you used amphetamines (speed) since the last visit?..... ☐ Yes (1) ☐ No (2)
If No, skip to question 5e.

If you used this drug, how often? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

e. Have you used methamphetamines (crystal meth, MDMA) ? ..... ☐ Yes (1) ☐ No (2)
If No, skip to question 5f.

How often have you used this drug since the last visit? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

f. Have you used barbiturates (downers)?..... ..... ☐ Yes (1) ☐ No (2)
If No, skip to question 5g.

How often have you used this drug since the last visit? ***(Check one)***

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

Pt. No.☐☐ ☐☐☐☐ ☐ * Seq. No.☐ ** Step No. ☐ Date ☐☐☐ ☐☐ ☐☐☐☐
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5. Continued. Please check "Yes" or "No" for each question:

g. Have you used any other street drug since the last visit (Ecstasy)? ☐ Yes (1) ☐ No (2)

If No, skip to question 6.

Specify other drug [30]:_____

If you used this drug, how often?

(Check one)

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

6. Have you used prescription drugs (codeine, valium, xanax) for which you did not have a prescription from a doctor since the last visit? ..... ☐ Yes (1) ☐ No (2)

If No, skip to question 7.

Specify other drug [30]:_____

How often have you used this drug since the last visit?

(Check one)

Daily	5 or 6 Times A Week	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1

7. Are you currently in methadone treatment? ..... ☐ Yes (1) ☐ No (2)

8. Have you been in methadone treatment since the last visit? ..... ☐ Yes (1) ☐ No (2)

Language: ☐ E
English

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