

RETROVIRUS EPIDEMIOLOGY DONOR STUDY-II (REDS-II)

HIV RISK FACTOR QUESTIONNAIRE

Thank you for taking the time to help us with this important study. Participation in this study is entirely voluntary. You may refuse to participate now, or at any time during the process. Refusal to participate in the study or withdrawing from the study will involve no penalty.

You do not have to answer any questions you do not wish to, and you may stop at any time. You may refuse to answer any question(s) that make(s) you feel uncomfortable or upset(s) you.

Date: ___ / ___ / ___ (D D / M M / Y Y Y Y)

Study identification number: ___ - _____ - ___

1. When were you born?	19__ __ (year)
2. What is your gender?	1 <input type="checkbox"/> Female 2 <input type="checkbox"/> Male
3. What is your place of birth?	_____ City/county Province
4. What is your ethnicity?	1 <input type="checkbox"/> Han 2 <input type="checkbox"/> Hui 3 <input type="checkbox"/> Uygur 4 <input type="checkbox"/> Man 5 <input type="checkbox"/> Dai 6 <input type="checkbox"/> Other, specify _____
5. What is your current occupation?	1 <input type="checkbox"/> Worker 2 <input type="checkbox"/> Farmer 3 <input type="checkbox"/> Business 4 <input type="checkbox"/> Service 5 <input type="checkbox"/> Education/research/government 6 <input type="checkbox"/> Military/Police 7 <input type="checkbox"/> Medicine/Health care 8 <input type="checkbox"/> Student 9 <input type="checkbox"/> Other, specify _____
6. What is the highest level of education you have received?	1 <input type="checkbox"/> Primary school or less 2 <input type="checkbox"/> Junior high school 3 <input type="checkbox"/> High School or vocational school 4 <input type="checkbox"/> Bachelor's degree 5 <input type="checkbox"/> Graduate level degree 6 <input type="checkbox"/> Other, specify _____
7. What is your marital status?	1 <input type="checkbox"/> Never married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Divorced 4 <input type="checkbox"/> Separated 5 <input type="checkbox"/> Widowed 6 <input type="checkbox"/> Other, specify _____

<p>8. How many times have you donated blood?</p> <p>a. Year and type of each blood donation (If you have donated blood more than 4 times, please list the most recent three)</p>	<p>___ __ time (s)</p> <p>1. ___ __ __ __ (year) Donation type: <input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation</p> <p>2. ___ __ __ __ (year) Donation type: <input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation</p> <p>3. ___ __ __ __ (year) Donation type: <input type="checkbox"/> Whole blood donation <input type="checkbox"/> Apheresis donation</p>
<p>9. How much do you agree or disagree about phrases below:</p> <p>a. It's important that I received blood test results from blood donation.</p> <p>b. I think blood donation is a good, fast, anonymous way to get my blood test.</p> <p>c. One of my reasons for donating blood is to find out if I have HIV and/or hepatitis infection.</p>	<p>1 <input type="checkbox"/> Do not agree at all 2 <input type="checkbox"/> Disagree a little 3 <input type="checkbox"/> Agree a little 4 <input type="checkbox"/> Agree very much</p> <p>1 <input type="checkbox"/> Do not agree at all 2 <input type="checkbox"/> Disagree a little 3 <input type="checkbox"/> Agree a little 4 <input type="checkbox"/> Agree very much</p> <p>1 <input type="checkbox"/> Do not agree at all 2 <input type="checkbox"/> Disagree a little 3 <input type="checkbox"/> Agree a little 4 <input type="checkbox"/> Agree very much</p>
<p>10. Have you ever received acupuncture treatment?</p> <p>a. In the 12 months before your most recent donation, did you have acupuncture?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 11 99 <input type="checkbox"/> Unknown → SKIP TO 11</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> Unknown</p>
<p>11. In the 12 months before your most recent donation, did you have any injection (including intravenous and intramuscle injections)?</p> <p>a. How many times did you have injection(s)?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 12 99 <input type="checkbox"/> Unknown → SKIP TO 12</p> <p>___ __ times</p>

<p>12. Have you had any finger sticks?</p> <p>a. In the 12 months before your most recent donation, did you have finger sticks?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 13 99 <input type="checkbox"/> Unknown → SKIP TO 13</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> Unknown</p>
<p>13. Have you ever had in-patient medical surgery?</p> <p>a. In the 12 months before your most recent donation, did you have in-patient medical surgery?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 14 99 <input type="checkbox"/> Unknown → SKIP TO 14</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> Unknown</p>
<p>14. Have you ever had out-patient medical surgery?</p> <p>a. In the 12 months before your most recent donation, did you have out-patient medical surgery?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 15 99 <input type="checkbox"/> Unknown → SKIP TO 15</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> Unknown</p>
<p>15. Have you ever had cosmetic surgery (e.g. laser, eye/lip surgery, collagen injection, dermal abrasion)?</p> <p>a. In the 12 months before your most recent donation, did you have cosmetic surgery?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a 2 <input type="checkbox"/> No → SKIP TO 16 99 <input type="checkbox"/> Unknown → SKIP TO 16</p> <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 99 <input type="checkbox"/> Unknown</p>
<p>16. Have you ever received a blood transfusion?</p> <p>a. How many times did you have blood transfusions?</p> <p>b. Year of your first time of blood transfusion?</p> <p>c. Year of your last time of blood transfusion?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER a, b AND c 2 <input type="checkbox"/> No → SKIP TO 17 99 <input type="checkbox"/> Unknown → SKIP TO 17</p> <p>___ ___ times</p> <p>___ ___ ___ ___ (year)</p> <p>___ ___ ___ ___ (year)</p>

<p>17. Have you ever had any dental cleaning?</p> <p>a. In the 12 months before your most recent donation, did you have dental cleaning?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 18</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 18</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>18. Have you ever had any dental surgery, such as root canal treatment or tooth extraction?</p> <p>a. In the 12 months before your most recent donation, did you have dental surgeries?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 19</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 19</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>19. Have you ever had any endoscopy (such as gastroscopy and colonoscopy)?</p> <p>a. In the 12 months before your most recent donation, did you have endoscopies?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 20</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 20</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>20. When you had acupuncture, finger sticks, or injections, were needles and syringes used disposable?</p>	<p>1 <input type="checkbox"/> Seldom</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>3 <input type="checkbox"/> Often</p> <p>4 <input type="checkbox"/> Always</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>21. Have you ever been told that you are at risk for spreading diseases through your blood?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>22. Have you ever been deferred as a blood donor?</p> <p>a. For what reason were you deferred?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 23</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 23</p> <p>Specify _____</p>

<p>23. Have you ever been previously diagnosed with hepatitis?</p> <p>a. What type(s) of hepatitis did you have?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 24</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 24</p> <p>1 <input type="checkbox"/> HAV</p> <p>2 <input type="checkbox"/> HBV</p> <p>3 <input type="checkbox"/> HCV</p> <p>4 <input type="checkbox"/> Other, specify _____</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>24. Have you ever been previously diagnosed with syphilis, gonorrhea, or any other sexually transmitted disease?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>25. Have any of your family members had hepatitis?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>26. Have any of your family members had HIV/AIDS?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>27. Have you ever had household contact with someone with hepatitis or HIV/AIDS?</p> <p>a. In the 12 months before your most recent donation, did you have household contact with someone with hepatitis or HIV/AIDS?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 28</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 28</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>28. Have you ever used needles to shoot street drugs?</p> <p>a. How long have you shot drugs?</p> <p>b. How many times per month did you shoot drugs?</p> <p>c. Have you ever shared needles or syringes with others to inject street drugs?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER a, b AND c</p> <p>2 <input type="checkbox"/> No → SKIP TO 29</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 29</p> <p>___ __ years</p> <p>___ __ times/month</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>

<p>29. Have you ever used illegal oral or intranasal drugs without doctor's prescription?</p> <p>a. In the 12 months before your most recent donation, did you use illegal oral or intranasal drugs without doctor's prescription?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 30</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 30</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>30. Have you ever lived with a person with illegal injection?</p> <p>a. In the 12 months before your most recent donation, did you live with a person with illegal injection?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 31</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 31</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>31. Are any of your close friends or family members intravenous drug users?</p>	<p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>32. Have you had 2 or more sexual partners of the opposite sex?</p> <p>a. How many heterosexual partners did you have?</p> <p>b. How often do you or your sex partner use a condom when you have sex with your heterosexual partner?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER a AND b</p> <p>2 <input type="checkbox"/> No → SKIP TO 33</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 33</p> <p>1 <input type="checkbox"/> 2-4</p> <p>2 <input type="checkbox"/> 5-7</p> <p>3 <input type="checkbox"/> 8-10</p> <p>4 <input type="checkbox"/> >10</p> <p>1 <input type="checkbox"/> Never</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>3 <input type="checkbox"/> Half of time</p> <p>4 <input type="checkbox"/> Most of time</p> <p>5 <input type="checkbox"/> Always</p>

<p>33. (For male only) In your lifetime, have you ever had sex with another male?</p> <p>a. How many times did you have sex with males?</p> <p>b. How many male partners have you had sex with?</p> <p>c. How often do you or your sex partner use a condom when you have sex with male partner?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER a, b AND c</p> <p>2 <input type="checkbox"/> No → SKIP TO 34</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 34</p> <p>___ __ times</p> <p>___ __ partners</p> <p>1 <input type="checkbox"/> Never</p> <p>2 <input type="checkbox"/> Sometimes</p> <p>3 <input type="checkbox"/> Half of time</p> <p>4 <input type="checkbox"/> Most of time</p> <p>5 <input type="checkbox"/> Always</p>
<p>34. Have you ever paid or received money for having sex?</p> <p>a. How many times have you paid or received money for having sex?</p> <p>b. In the 12 months before your most recent donation, did you pay or receive money for having sex?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER a AND b</p> <p>2 <input type="checkbox"/> No → SKIP TO 35</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 35</p> <p>___ __ times</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>35. Have you ever had a sex partner that was an intravenous drug user?</p> <p>a. In the 12 months before your most recent donation, did you have a sex partner that was an intravenous drug user?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 36</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 36</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>36. In the past ten years, have you ever had a sex partner who had a positive test for syphilis, gonorrhea, or any other sexually transmitted disease?</p> <p>a. In the 12 months before your last donation, did you have a sex partner who had a positive test for syphilis, gonorrhea, or any other sexually transmitted disease?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 37</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 37</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>

<p>37. In the past ten years, have you ever had a sex partner who had been diagnosed with hepatitis or HIV/AIDS?</p> <p>a. In the 12 months before your most recent donation, did you have a sex partner who had been diagnosed with hepatitis or HIV/AIDS?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 38</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 38</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>38. In the past one year, have you had sexual contact with anyone who received blood transfusion?</p> <p>a. In the 12 months before your most recent donation, did you have sexual contact with anyone who received blood transfusion?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 39</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 39</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>39. Have you ever contacted with human blood and other human body fluids in your workplace?</p> <p>a. In the 12 months before your most recent donation, did you contact with human blood and other human body fluids in your workplace?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 40</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 40</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>40. Have you ever had a tattoo?</p> <p>a. In the 12 months before your most recent donation, did you have a tattoo?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 41</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 41</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>
<p>41. Have you ever had your ears or other body parts pierced?</p> <p>a. In the 12 months before your most recent donation, did you have your ears or other body parts pierced?</p>	<p>1 <input type="checkbox"/> Yes → ANSWER QUESTION a</p> <p>2 <input type="checkbox"/> No → SKIP TO 42</p> <p>99 <input type="checkbox"/> Unknown → SKIP TO 42</p> <p>1 <input type="checkbox"/> Yes</p> <p>2 <input type="checkbox"/> No</p> <p>99 <input type="checkbox"/> Unknown</p>

42. Did you receive notification from blood center about your infection status?

- 1 Yes → **ANSWER a AND b**
2 No → **END**
99 Unknown → **END**

a. Did you seek further testing or health care according to the instruction of the notification?

- 1 Yes → **END**
2 No → **ANSWER QUESTION b**
99 Unknown → **END**

b. Are you planning to seek further testing or health care according to the instruction of the notification?

- 1 Yes
2 No
99 Unknown

Thank you very much for your participation!