

Unique ID _____

Form Approved
OMB Control No. 0920-xxxx
Exp. Date xx/xx/20xx

3 and 6 Month Follow-Up Questionnaire for Men

Section A: To be completed by the Receptionist

1 Unique Study ID: □□□□□□□□

First, I would like to ask you if your contact information has changed since your last visit. If someone else answers the phone, we will not tell them any information about the study. I would like to remind you that your involvement in the study is completely confidential.

2 Address of residence: _____

3 Village of residence: _____

4 District of residence: _____

5 Telephone: _____

6 Other contact/next of kin: _____

CHECKED BY RECEPTIONIST:

Signature: _____ Date: **(DD/MM/YYYY)** ____/____/____

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Section B: To be completed by the Nurse

Thank you for participating in this study. I will be conducting your interview today and it will last about 10 minutes. I ask all participants in this study the same questions. All of your answers are confidential. I will mark a response to every question, but if you are not comfortable answering any question, you can tell me to mark “no answer”. You can also ask me to go back, or repeat any questions. Are you comfortable proceeding with the interview now?

Now, I would like to ask you a few questions about the time since we last saw you.

7 How is your overall health and wellbeing now, *compared to your last study visit*?

- 01** - My overall health now is the same as how I felt at my last study visit
- 02** - My overall health now is worse than how I felt at my last study visit
- 03** - My overall health now is better than how I felt at my last study visit
- 88** – Don’t know
- 99** - Refused

8 *Since your last study visit*, do you have any **new** health problems?

- 01** - Yes
- 02** - No **SKIP TO 9**
- 88** - Don’t know/not sure **SKIP TO 9**
- 99** - Refused **SKIP TO 9**

9 If yes, please specify the new health problems you are experiencing. **MARK ALL THAT APPLY.**

Symptom	Yes	No	Refused
General (<i>fevers, weight loss, loss of appetite, feeling tired</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye problems (<i>itching, ocular redness, eye lid inflammation, blurred vision, complete loss of vision</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Joint problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurological (<i>loss of strength in arms, or legs, inability to balance</i>)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin problems (itching, spots)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychiatric problems (hallucinations, delusions)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychological problems (depression, anxiety)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other (e.g. loss of hair) SPECIFY _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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		<i>Recovered</i>	<i>Died</i>	<i>Refused</i>			
1		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
2		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
3		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
4		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
5		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
6		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			
7		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>			

13 *Since our last meeting*, have you participated in sexual activity? Sexual activity includes oral, vaginal, or anal sex.

- 01 - Yes
- 02 - No **SKIP TO 14**
- 99 - Refused **SKIP TO 14**

14 If yes, how often did you use a condom during sex? **Choose one.**

- 01 - Never
- 02 - Some of the time
- 03 - Every time
- 88 - Don't know
- 99 - Refused

15 How often have you engaged in sexual activities *since your last visit*?

- 01 - Every day
- 02 - 3 or more time a week
- 03 - 2 times a week
- 04 - Once per week
- 05 - Once per month
- 06 - Once
- 88 - Don't know
- 99 - Refused

16 *Since your last visit*, did you make any women pregnant?

- 01 - Yes
- 02 - No
- 88 - Don't know/not sure
- 99 - Refused

16a If Yes, how many times have you made a woman pregnant since your last visit?

_____ estimated

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15 Thank you very much for participating in the survey today. Do you have any other comments or concerns you would like to share about these topics?

16 Result of questionnaire:

01 - Completed

02 - Partially completed

03 - Participant refused

04 - Other → Specify: _____

CHECKED BY NURSE:

Signature _____

Date: ____/____/_____
(DD / MM / YYYY)

CHECKED BY RESEARCH ASSISTANT:

Signature _____

Date: ____/____/_____
(DD / MM / YYYY)