Questionnaire on HIV

It is VERY IMPORTANT that we have details on how your HIV infection has changed or affected your day-to-day functioning. This information will be used for your disability application. We realize that some of these questions may be difficult or very personal. However, please give us as much detail as possible. We need DETAILS to show how your infection has affected your day-to-day life. When you answer these questions, think of what you were able to do before you became ill. Then, describe what you can no longer do. Again, if you have ANY questions, please call me at the number on the attached letter. (If you need more space, use the back of this form.)

- When did you test HIV positive? Where?
- What was your lowest T-cell count? When? Where?
- What medications do you take?
- Do you have health insurance/Medicaid?

Please check off any of the following that you have, how long you have had the condition, and provide details.

_____FATIGUE

_____SLEEP PROBLEMS

_____NIGHT SWEATS

_____SWOLLEN GLANDS

_____DIARRHEA

_____WEIGHT LOSS:

NORMAL WEIGHT
WHEN
CURRENT WEIGHT

_____LOSS OF APPETITE

_____RASHES/SKIN SORES

_____THRUSH

_____NUMBNESS IN HANDS/FEET

_____SHINGLES (HERPES)

_____JOINT PAINS

_____PNEUMONIA

_____TB

_____SINUS PROBLEMS

_____ENDOCARDITIS

_____HEADACHES

_____VISUAL PROBLEMS

_____CANCER

_____KAPOSI'S SARCOMA (KS)

_____ANAL/GENTIAL HERPES

_____SEXUALLY TRANSMITTED DISEASE (STD)

_____DEPRESSION/ANXIETY

_____MEMORY PROBLEMS

(FOR WOMEN ONLY)

_____VAGINAL YEAST INFECTION

_____OTHER GYNECOLOGICAL PROBLEMS
(STANDARD, DISEASES, PAIN)

Please describe any additional problems/comments:

1. How has your illness affected your day-to-day activities? Has pain, fatigue or side effects of medication limited your ability to take care of yourself? Are there some things you just can't do anymore? (e.g. household chores, shopping, preparing meals, bathing or dressing, going outside, paying bills, driving, using public transportation, hobbies or recreational activities, etc.) How has your illness affected these areas?

2. Do friends, family or volunteers assist you? If so, how do they help you? What do they do?

3. How has your illness affected your ability to socialize? (e.g. visiting family or friends, enjoying or getting along with family or friends, going out with other people, etc.) Has pain, fatigue or the side effects of medication affected your social life?

4. How has your illness affected your ability to complete tasks in a timely manner? (e.g. work, household chores, shopping, bathing or dressing, getting to appointments, etc.) Has pain, fatigue or the side effects of medication affected these areas?

5. Has your illness caused periods where you had to stop your usual work or day-to-day activities? (e.g. hospitalizations, severe infections, periods of fatigue or depression, etc.) Please describe these periods, when they occurred and how long they lasted.

6. Have you felt anxious, depressed or confused? Do you have mood swings? Have these changed since you became ill? Do you see a counselor, therapist, or participate in a group? Please describe.

7. In your own words, how does HIV infection prevent you from working?

8. Could you give us the name, address and phone number of two people who know you and how your HIV infection has affected you? (Such as friends, visiting nurses, etc.) We may contact these people to get more information about your condition.

Contact One:	**Contact Two:**
Name	Name
Address	Address
City, State and Zip Code	City, State and Zip Code
Telephone Number	Telephone Number

9. Is there anything else about HIV infection that you haven't told us that you think is important? If so, please tell us

Signature

Signature of Person Completing this Form (if different)

Print Name

Date

Telephone