

## Baseline Survey Questionnaire for Tuberculosis Infection and Disease Cohort Study among PLHIV

Personal Project ID: □□-□□□□ Name: \_\_\_\_\_

### I. Basic Information

Sex: 1. Male 2. Female

Date of Birth: \_\_\_\_\_ YYYY/MM/DD

Date of HIV Diagnosis: \_\_\_\_\_ YYYY/MM/DD

Diagnosis Type: 1. Follow-up Management 2. New Diagnosis (within one year)

Date of Antiretroviral Therapy Initiation: \_\_\_\_\_ YYYY/MM/DD

Current Treatment Regimen: \_\_\_\_\_

Date of Enrollment: \_\_\_\_\_ YYYY/MM/DD

BCG Scar (scar after BCG vaccination, usually on the outer side of the left upper arm):

1. Yes 2. No

Height: \_\_\_\_\_ cm Weight: \_\_\_\_\_ Kg

### II. Past Medical History and Tuberculosis Contact History

a) Have you ever been diagnosed with or currently have any of the following diseases?

Diabetes No Yes Date of Diagnosis: \_\_\_\_\_ YYYY/MM/DD

Hypertension No Yes Date of Diagnosis: \_\_\_\_\_ YYYY/MM/DD

Tuberculosis No Yes Date of Diagnosis: \_\_\_\_\_ YYYY/MM/DD

Tumor No Yes Date of Diagnosis: \_\_\_\_\_ YYYY/MM/DD  
Please clarify the position: \_\_\_\_\_

Other Chronic Diseases No Yes Date of Diagnosis: \_\_\_\_\_ YYYY/MM/DD  
Please clarify the disease: \_\_\_\_\_

b) Have you had contact with a tuberculosis patient in the last six months?

1. Yes 2. No 3. Don't know

### III. Smoking History

What is your smoking habit?

1. Currently smoking (Average cigarettes/day: \_\_\_\_\_, Total smoking years: \_\_\_\_\_)
2. Past smoker, quit for more than 1 month (Past average cigarettes/day: \_\_\_\_\_, Total smoking years: \_\_\_\_\_)
3. Never smoked

### IV. Tuberculosis history, contact history and susceptible symptoms

s1	Have you recently developed tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
s2	Have you recently had contact with a TB patient?	<input type="checkbox"/> No <input type="checkbox"/> Yes

<b>s3</b>	Have you had a cough or produced sputum in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s4</b>	Have you had hemoptysis (coughing up blood) or blood-streaked sputum in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s5</b>	Have you had a low-grade fever in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s6</b>	Have you had night sweats (excessive sweating during sleep) in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s7</b>	Have you experienced weight loss in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes

## V. Examination Results

	Test Item	Result	Test Date (YYYY/MM/DD)
<b>b1</b>	IGRA	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Indeterminate <input type="checkbox"/> 4. Not Tested	
<b>b2</b>	CD4 Cell Count	_____ cells/ $\mu$ l <input type="checkbox"/> Not Tested	
<b>b3</b>	HIV Viral Load	_____ copies/ml <input type="checkbox"/> Not Tested	
<b>b4</b>	HIV Viral Typing	<input type="checkbox"/> Not Tested	
<b>b5</b>	HIV Drug Resistance Testing	<input type="checkbox"/> Not Tested	
		Drug 1: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
		Drug 2: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
		Drug 3: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
		Drug 4: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
		Drug 5: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
<b>b6</b>	HBsAg	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b7</b>	Anti-HBs	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b8</b>	HBeAg	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b9</b>	Anti-HBe	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b10</b>	Anti-HBc	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b11</b>	Anti-HCV Antibody	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b12</b>	HCV RNA	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b13</b>	Treponemal Serological Test	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b14</b>	Non-treponemal Serological Test	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b15</b>	Chest X-ray	<input type="checkbox"/> 1. Normal <input type="checkbox"/> 2. Abnormal <input type="checkbox"/> 3. Not Tested	
<b>b16</b>	Chest CT	<input type="checkbox"/> 1. Normal <input type="checkbox"/> 2. Abnormal <input type="checkbox"/> 3. Not Tested	
<b>b17</b>	Sputum Smear	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	

<b>b18</b>	Sputum Culture	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b19</b>	Gene-Xpert	<input type="checkbox"/> 1. Positive, Rifampicin Sensitive <input type="checkbox"/> 2. Positive, Rifampicin <b>Resistant</b> <input type="checkbox"/> 3. Negative <input type="checkbox"/> 4. Not Tested	
<b>b20</b>	Other test, Please specify:		

**Interviewer Signature:** \_\_\_\_\_ **Interview Date:** \_\_\_\_\_

## Follow-up Survey Questionnaire for Tuberculosis Infection and Disease Cohort Study among PLHIV

Personal Project ID: □□-□□□□ Name: \_\_\_\_\_

Current Weight: \_\_\_\_\_ Kg (Measured and filled by the interviewer)

Follow-up Date: \_\_\_\_\_ (YYYY/MM/DD), Follow-up No. : \_\_\_\_\_

### I. Tuberculosis history, contact history and susceptible symptoms

<b>s1</b>	Have you recently developed tuberculosis?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s2</b>	Have you recently had contact with a TB patient?	<input type="checkbox"/> No <input type="checkbox"/> Yes
<b>s3</b>	Have you had a cough or produced sputum in the past 2 weeks?	<input type="checkbox"/> No <input type="checkbox"/> Yes
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		Drug 3: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
		Drug 4: _____ <input type="checkbox"/> Low-level <input type="checkbox"/> Intermediate <input type="checkbox"/> High-level	
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<b>b17</b>	Sputum Smear	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b18</b>	Sputum Culture	<input type="checkbox"/> 1. Positive <input type="checkbox"/> 2. Negative <input type="checkbox"/> 3. Not Tested	
<b>b19</b>	Gene-Xpert	<input type="checkbox"/> 1. Positive, Rifampicin Sensitive <input type="checkbox"/> 2. Positive, Rifampicin <b>Resistant</b> <input type="checkbox"/> 3. Negative <input type="checkbox"/> 4. Not Tested	
<b>b20</b>	Other test, Please specify:		

**Interviewer Signature:** \_\_\_\_\_ **Interview Date:** \_\_\_\_\_