New Enrollment Baseline
FORM 1—ANTI-VIRAL DRUGS

ID Number | **Visit No.** 3 6 5 | **DATE** (Jan–Dec; DAY; YEAR 01, 02)

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 21.B(1) IF TAKEN IN LAST 6 MONTHS.

- ◯ 3-TC (Epivir, Lamivudine)
- ◯ Abacavir (Ziagen)
- ◯ Amprenavir (Agenerase)
- ◯ AZT (Retrovir, Zidovudine)
- ◯ Atazanavir (BMS-232632)
- ◯ Combivir (AZT & 3-TC)
- ◯ d4T (Zerit, Stavudine)
- ◯ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ◯ ddI (dideoxyinosine, Didanosine, Videx)
- ◯ Delavirdine (Rescriptor)
- ◯ Efavirenz (Sustiva)
- ◯ Indinavir (Crixivan)
- ◯ Lopinavir/r (Kaletra)
- ◯ Nelfinavir (Viracept)
- ◯ Nevirapine (Viramune)
- ◯ Ritonavir (Norvir)
- ◯ Saquinavir (Invirase, Fortovase)
- ◯ Tenofovir (Viread)
- ◯ Trizivir (abacavir + zidovudine + lamivudine)
- ◯ T-20
- ◯ Other → **Name of Drug:** ________ → **Drug Code**

Drug Code
0 100 200 300 400 500 600 700 800 900
0 10 20 30 40 50 60 70 80 90
0 1 2 3 4 5 6 7 8 9

You said you were taking (DRUG) during the last 6 months:

1.A. Did you take this drug as part of a research study?

◯ NO (GO TO Q2) ◯ YES

B. Was this study one in which you may have taken a placebo (not the actual drug) or in which you were blinded to the treatment?

◯ NO ◯ YES

C. Was this part of the AIDS Clinical Trial Group (ACTG)?

◯ NO ◯ DON'T KNOW ◯ YES

D. Are you currently taking this drug as part of the research study?

◯ NO ◯ YES

IF YES: STOP IF PARTICIPANT WAS BLINDED TO THE TREATMENT; IF UNBLINDED, SKIP TO Q4.

E. [During the last 6 months] In what month and year did you most recently take this drug as part of the research study?

Month	YEAR
Jan	
Feb	
Mar	93
Apr	94
May	95
June	96
July	97
Aug	98
Sept	99
Oct	00
Nov	01
Dec	02

STOP IF PARTICIPANT WAS BLINDED TO THE TREATMENT AND GO TO NEXT DRUG.

2. Are you currently taking this drug [not as part of a research study]?

◯ NO ◯ YES (GO TO Q4)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

3. [During the last 6 months] In what month and year did you most recently take this drug?

Month	YEAR
Jan	
Feb	
Mar	93
Apr	94
May	95
June	96
July	97
Aug	98
Sept	99
Oct	00
Nov	01
Dec	02

4. According to your doctor, how many times a day should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

① ② ③ ④ ⑤ ⑥ ⑦

5. According to your doctor, how many pills should you take each time?

① ② ③ ④ ⑤ ⑥ ⑦

Please continue on the other side.

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6. Did you start taking this drug in the last 6 months?

◯ NO (GO TO Q8) ◯ YES

7. [During the last 6 months] In what month and year did you start taking this drug?

Month	YEAR
◯ Jan	
◯ Feb	
◯ Mar	93
◯ Apr	94
◯ May	95
◯ June	96
◯ July	97
◯ Aug	98
◯ Sept	99
◯ Oct	00
◯ Nov	01
◯ Dec	02

8. During the last 6 months, how long have you used (DRUG)?

◯ One week or less
◯ More than 1 week but less than 1 month
◯ 1–2 months
◯ 3–4 months
◯ 5–6 months
◯ More than 6 months

9. Have you experienced any of the following side effects while taking (DRUG)? (MARK ALL THAT APPLY)

◯ Low white blood cells (low neutrophils)
◯ Anemia (low red blood cells/low hemoglobin)
◯ Bleeding
◯ Dizziness/Headaches
◯ Nausea/Vomiting
◯ Abdominal pain (pancreatitis/abdominal bloating/cramps)
◯ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
◯ Burning/tingling in extremities (neuropathy/neuritis/numbness)
◯ Diarrhea
◯ Kidney stones
◯ Rash
◯ High blood sugar/Diabetes
◯ High cholesterol/High triglycerides
◯ Painful urination
◯ High blood pressure
◯ Abnormal changes in body fat
◯ Vivid nightmares or dreams
◯ Liver toxicity (abnormal liver function test)
◯ Insomnia or problems sleeping
◯ Other, specify:

1) ______________________
2) ______________________
3) ______________________

◯ None of the above

10. Did you stop taking this drug at any time during the last 6 months? [DOES NOT INCLUDE ALTERNATING DRUG USE]

◯ NO (GO TO Q12) ◯ YES

11. Why did you stop taking this drug? (MARK ALL THAT APPLY)

◯ Low white blood cells (low neutrophils)
◯ Anemia (low red blood cells/low hemoglobin)
◯ Bleeding
◯ Dizziness/Headaches
◯ Nausea/Vomiting
◯ Abdominal pain (pancreatitis/abdominal bloating/cramps)
◯ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
◯ Burning/tingling in extremities (neuropathy/neuritis/numbness)
◯ Diarrhea
◯ Kidney stones
◯ Rash
◯ High blood sugar/Diabetes
◯ High cholesterol/High triglycerides
◯ Painful urination
◯ High blood pressure
◯ Abnormal changes in body fat
◯ Vivid nightmares or dreams
◯ Liver toxicity (abnormal liver function test)
◯ Insomnia or problems sleeping
◯ Increased viral load
◯ Decreased viral load
◯ Hospitalized
◯ Personal decision
◯ Prescription changes by physician
◯ Too expensive
◯ Too much bother, inconvenient (ran out/vacation/unable to fill prescription)
◯ Changed to another drug in order to decrease the number of pills or dosing frequency
◯ Other, specify:

1) ______________________
2) ______________________
3) ______________________

12. On average, how often did you take your medication as prescribed?

◯ 100% of the time
◯ 95–99% of the time
◯ 75–94% of the time
◯ <75% of the time