

15

## FORM 1 – ANTI-VIRAL DRUGS

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 13.A.(2).

Name of Drug:

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

ID Number

Visit No.

Date

0	0	0	0	0
1	1	1	1	1
2	2	2	2	2
3	3	3	3	3
4	4	4	4	4
5	5	5	5	5
6	6	6	6	6
7	7	7	7	7
8	8	8	8	8
9	9	9	9	9

0	0	0
1	1	1
2	2	2
3	3	3
4	4	4
5	5	5
6	6	6
7	7	7
8	8	8
9	9	9

	DAY	YEAR
Jan		
Feb		
Mar	0	0
Apr	10	1
May	20	2
Jun	30	3
Jul		4
Aug		5
Sep		6
Oct		7
Nov		8
Dec		9

You said you were taking (DRUG) since your last visit.

1. A. Did you take this drug as part of a research study in which you may have taken a placebo (not the actual drug) or in which you were blinded to the treatment?

- ☐ NO (GO TO Q2)  
☐ YES

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

- ☐ NO (STOP, GO TO NEXT DRUG)  
☐ YES  
☐ DON'T KNOW (STOP, GO TO NEXT DRUG)

C. If YES, do you know the ACTG number?

- ☐ NO (STOP, GO TO NEXT DRUG)  
☐ YES

D. What is the number of that study?

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

(STOP, GO TO NEXT DRUG)

2. When did you first start taking this drug?

	DAY	YEAR
Jan		
Feb		
Mar	0	0
Apr	10	1
May	20	2
Jun	30	3
Jul		4
Aug		5
Sep		6
Oct		7
Nov		8
Dec		9

(USE "15" FOR DAY IF PARTICIPANT DOES NOT KNOW ACTUAL DAY)

3. A. Are you currently taking this drug?

- ☐ NO (GO TO Q4)  
☐ YES

B. Did you interrupt taking the (DRUG) since your last visit?

- ☐ NO (GO TO Q6)  
☐ YES

IF YES: For how long did you interrupt taking the (DRUG)?

- ☐ < 1 month  
☐ 1 - 3 months  
☐ > 3 to 6 months  
☐ > 6 months

(GO TO Q5)

4. On what date did you stop taking this drug?

	DAY	YEAR
Jan		
Feb		
Mar	0	0
Apr	10	1
May	20	2
Jun	30	3
Jul		4
Aug		5
Sep		6
Oct		7
Nov		8
Dec		9

(USE "15" FOR DAY IF PARTICIPANT DOES NOT KNOW EXACT DATE)

5. Why did you stop/interrupt taking this drug?

(MARK ALL THAT APPLY)

- ☐ Low white blood cells  
☐ Bleeding  
☐ Dizziness/Headaches  
☐ Nausea/Vomiting  
☐ Abdominal pain (pancreatitis)  
☐ Muscle pain or weakness (myopathy/myositis)  
☐ Burning/tingling in extremities (neuropathy/neuritis)  
☐ Other side effects, specify:  
  
☐ Prescription changed by physician  
☐ Too expensive  
☐ Too much bother, inconvenient  
☐ Other, specify:

6. Was this DRUG prescribed by your doctor?

- ☐ NO (GO TO Q11)  
☐ YES

7. What was the prescribed frequency?

- ☐ Every day  
☐ Weekly  
☐ Semi-monthly  
☐ Monthly  
☐ Once  
☐ Other, specify: →

8. We are interested in the most recent prescription from your physician. What was the dosage most recently prescribed (such as 200 mg 3 times per day = 600 mg)?

(RECORD PARTICIPANT'S COMPLETE RESPONSE)

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

☐ Don't Know

9. Did/do you take (DRUG) as prescribed?

☐ NO  
☐ YES (GO TO Q13)

10. Did/do you take (DRUG) on a different schedule than was prescribed?

☐ NO  
☐ YES

11. How often did/do you actually take (DRUG)?

☐ Every day  
☐ Weekly  
☐ Semi-monthly  
☐ Monthly  
☐ Once  
☐ Other, specify:

12. What total daily dose did/do you take?

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

(RECORD PARTICIPANT'S COMPLETE RESPONSE)

☐ Don't Know

13. Does this use represent a change from your use of (DRUG) at the time of your last visit?

☐ NO (GO TO NEXT DRUG)  
☐ YES, started, no further changes (GO TO NEXT DRUG)  
☐ YES, started and/or changed use

14. What was the nature of this change?

☐ Increased  
☐ Decreased

15. On what date did this change take place?

<input type="radio"/> Jan	DAY	YEAR
<input type="radio"/> Feb		
<input type="radio"/> Mar	0	0
<input type="radio"/> Apr	10	1
<input type="radio"/> May	20	2
<input type="radio"/> Jun	30	3
<input type="radio"/> Jul	4	86
<input type="radio"/> Aug	5	87
<input type="radio"/> Sep	6	88
<input type="radio"/> Oct	7	89
<input type="radio"/> Nov	8	90
<input type="radio"/> Dec	9	91

(USE "15" FOR DAY IF PARTICIPANT DOES NOT KNOW EXACT DAY)

16. Why did this change occur? (MARK ALL THAT APPLY)

☐ Low white blood cells  
☐ Bleeding  
☐ Dizziness/Headaches  
☐ Nausea/Vomiting  
☐ Abdominal pain (pancreatitis)  
☐ Muscle pain or weakness (myopathy/myositis)  
☐ Burning/tingling in extremities (neuropathy/neuritis)  
☐ Other side effects, specify:

☐ Prescription changed by physician  
☐ Too expensive  
☐ Too much bother, inconvenient  
☐ Other, specify:

GO TO NEXT DRUG LISTED IN Q.13.A. (2)