Visit No.

0

**ID Number** 

0000

O Jan

O Feb

Date

DAY

YEAR

 $\bigcirc$  > 6 months

(GO TO Q5)

## FORM 1 - ANTI-VIRAL DRUGS

COMPLETE	THE FOLL	OWING	FOR EACH	I DRUG	LISTED IN
QUESTION	13.A.(2).				

COMPLETE THE FOLLOWING FOR EACH DRUG LIST QUESTION 13.A.(2).	TED IN
Name of Drug: Drug Code	4 4 4 4 4 4 Jun 30 3 5 5 5 5 5 5 5 Jul 4
0 60 60 60 60 60 60 60 60 60 60 60 60 60	6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6 6
ou said you were taking (DRUG) since your last visit.	<u></u> Dec
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?	4. On what date did you stop taking this drug?    Jan   DAY   YEAR     Feb
○ NO (GO TO Q2)	(USE "15" FOR DAY IF PARTICIPAN
○ YES	O Mar 0 0 0 82 DOES NOT KNOW EXACT DATE)
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?	May       20       2       84         Jun       30       3       85         Jul       4       86         Aug       5       87         Sep       6       88         Oct       7       89         Nov       8       90
ONO (STOP, GO TO NEXT DRUG)	ODec 9 9
D. What is the number of that study?	5. Why did you stop/interrupt taking this drug?  (MARK ALL THAT APPLY)
0 60 60 60 60 60 60 60 60	O Low white blood cells
0 0 20 30 40 50 60 70 80 90	Bleeding
0 1 2 3 4 5 6 7 8 9 (STOP, GO TO NEXT DRUG)	O Dizziness/Headaches
When did you first start taking this drug?	○ Nausea/Vomiting
☐ Jan   DAY   YEAR	Abdominal pain (pancreatitis)
Feb	<ul><li>Muscle pain or weakness (myopathy/myositis)</li><li>Burning/tingling in extremities (neuropathy/neuritis)</li></ul>
Mar 0 0 82	Other side effects, specify:
Apr (0 1 8) (USE "15" FOR DAY IF PARTICIPANT DOES NOT KNOW ACTUAL DAY)	C union state errecta, appearry.
○ May  20 (2)   84	Prescription changed by physician
◯ Jun   30 ③   85	O Too expensive
○ Jul   4   86	Too much bother, inconvenient
Aug 5 87	Other, specify:
○ Sep     6     88       ○ Oct     7     89	
Nov 8 90	6. Was this DRUG prescribed by your doctor?
O Dec 9 9	NO (GO TO Q11)
	YES
A. Are you currently taking this drug?	
NO (GO TO Q4)	7. What was the prescribed frequency?
YES	Every day
B. Did you interrupt taking the (DRUG) since your last visit?	Weekly
NO (GO TO Q6)	Semi-monthly
YES  IF YES: For how long did you interment taking the (DRUC)	Monthly
IF YES: For how long did you interrupt taking the (DRUG)?	Once
1 - 3 months	Other, specify:
> 3 to 6 months	

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)	13. Does this use represent a change from your use of		
THE RESIDENCE OF THE PROPERTY	(DRUG) at the time of your last visit?		
TOTAL UNITS	O NO (GO TO NEXT DRUG)		
DAILY DOSE CODE	YES, started, no further changes (GO TO NEXT DRUG)		
0 0 0 0 O Don't Know	YES, started and/or changed use		
0 0 0 0 O Don't Know	14 What was the nature of this change?		
(w) (20) (2) (20) (2) (20) (2) (30) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	14. What was the nature of this change?		
(a) (a) (a) (a) (b) (a) (a) (b) (a) (a) (a) (a) (a) (a) (a) (a) (a) (a	ODecreased		
۩ 400 40 4 40 4 40 4 A			
<b>∞ 60 60 6 60 6</b>	15. On what date did this change take place?		
<b>∞ 60 60 60 60 60 60 60 60 60 60 60 60 60 </b>			
(10) (10) (10) (10) (10) (10) (10) (10)	Jan DAY YEAR		
€00 80 8 8 8 8 8 9 9 9 9 9 9 9 9 9 9 9 9	Feb (USE "15" FOR DAY IF PARTICIPAN DOES NOT KNOW EXACT DAY)		
	Apr (0) 1) 83		
9. Did/do you take (DRUG) as prescribed?	May 20 2 84		
○ NO	Jun 30 3 85		
YES (GO TO Q13)	Jul 4 86		
	O Aug   5 87		
10. Did/do you take (DRUG) on a different schedule than was prescribed?	Sep 6 88		
○ NO	Oct 7 89 Nov 8 90		
○ YES	Dec 9 9		
	16. Why did this change occur? (MARK ALL THAT APPI		
11. How often did/do you actually take (DRUG)?	O Low white blood cells		
O Every day	© Bleeding		
<ul><li>○ Weekly</li><li>○ Semi-monthly</li></ul>	Dizziness/Headaches     Neuros A/coniting		
Monthly	<ul><li>Nausea/Vomiting</li><li>Abdominal pain (pancreatitis)</li></ul>		
Once	Muscle pain or weakness (myopathy/myositis)		
Other, specify:	Burning/tingling in extremities (neuropathy/neuritis)		
	Other side effects, specify:		
10 10/1-4 4-4-1 1-7 1-1 1-1 1-1 1-1 1-1 1-1			
12. What total daily dose did/do you take?			
TOTAL UNITS (RECORD PARTICIPANT'S COMPLETE RESPONSE)	Prescription changed by physician		
TOTAL UNITS RESPONSE) DAILY DOSE CODE	Too expensive		
The second secon	○ Too much bother, inconvenient		
0 0 0 0 O Don't Know	Other, specify:		
(20) (20) (2) (2) (2) (30) (3) (3) (3) (3)			
600 900 30 3 3 30 3 600 400 40 4 40 4			
€ 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5			
<b>∞ ∞ ⊚ 6 ⊚ 6</b>			
(w) (w) (v) (v) (v) (v) (v) (v) (v) (v) (v) (v			
<b>∞∞∞</b> 80 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8 8			
⊚ ⊚ ⊚ 9	ISTED IN Q.13.A. (2)		

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