21 FORM 1 - ANTI-VIRAL DRUGS

ID Number | **Visit No.** | **DATE** (DAY / YEAR)

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 18.A(2).

- ◯ Acyclovir (ACV, Zovirax)
- ◯ AL-721
- ◯ Alpha Interferon
- ◯ Ampligen
- ◯ AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)
- ◯ AZT/ddC
- ◯ AZT/ddI
- ◯ AZT/ddI/ddC
- ◯ Beta Interferon
- ◯ d4T
- ◯ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ◯ ddI (dideoxyinosine, Didanosine, Videx)
- ◯ ddI/ddC
- ◯ Dextran-Sulfate
- ◯ Foscarnet (Phosphonoformate, PFA)
- ◯ Peptide T
- ◯ Recombinant CD4
- ◯ Ribavirin
- ◯ Other →

Name of Drug:

Drug Code

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

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 (GO TO F)
- ◯ YES
- ◯ DON'T KNOW (GO TO F)

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

- ◯ NO (GO TO F)
- ◯ YES

E. What is the number of that study?

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

- ◯ NO
- ◯ YES

(STOP, GO TO NEXT DRUG)

2. Since your last visit in (MONTH), how long have you used this (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

3. Did you alternate your use of this drug with another anti-viral drug?

- ◯ NO (GO TO Q5)
- ◯ YES

4. If YES, how often did you alternate these drugs?

- ◯ More often than weekly
- ◯ Weekly
- ◯ Every two weeks
- ◯ Monthly
- ◯ Less often than monthly
- ◯ Other alternating schedule

} (GO TO Q8)

5. Did you stop altogether or decrease your daily dose of (DRUG) since your last visit?

- ◯ NO (GO TO Q8)
- ◯ YES

Please continue on the other side.

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6. Why did you stop taking or decrease 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)
- ◯ Hospitalized
- ◯ Personal decision
- ◯ Prescription changes by physician
- ◯ Too expensive
- ◯ Too much bother, inconvenient (ran out/vacation/unable to fill prescription)
- ◯ Other, specify:

1) _____
2) _____
3) _____

7. Did you restart or increase your use of this drug?

- ◯ NO
- ◯ YES

8. What is the most recent total daily dose that you took? For example, 200 mg 3 times per day = 600 mg.

TOTAL DAILY DOSE

0	0	0	0
1000	100	10	1
2000	200	20	2
3000	300	30	3
4000	400	40	4
5000	500	50	5
6000	600	60	6
7000	700	70	7
8000	800	80	8
9000	900	90	9

UNITS CODE

0	0
10	1
20	2
30	3
40	4
50	5
60	6
70	7
80	8
90	9

(RECORD PARTICIPANT'S COMPLETE RESPONSE)

◯ Don't Know

9. Are you currently taking this drug?

- ◯ NO
- ◯ YES