26 FORM 1—ANTI-VIRAL DRUGS

ID Number | Visit No. | DATE (Jan–Dec | DAY | YEAR)

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

- ○ 3-TC (Epivir, Lamivudine)
- ○ Acyclovir (ACV, Zovirax)
- ○ Alpha Interferon
- ○ AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)
- ○ AZT/3-TC Blinded Trial
- ○ AZT/ddC Blinded Trial
- ○ AZT/ddI Blinded Trial
- ○ AZT/ddI/ddC Blinded Trial
- ○ d4T (Zerit, Stavudine)
- ○ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ○ ddI (dideoxyinosine, Didanosine, Videx)
- ○ Delavirdine
- ○ Famcyclovir
- ○ Foscarnet (Phosphonoformate, PFA)
- ○ Indinavir (Crixivan)
- ○ Nevirapine
- ○ Recombinant CD4
- ○ Ritonavir (Norvir)
- ○ Saquinavir (Invirase)
- ○ Other →

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)

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) ○ DON'T KNOW (GO TO F)
○ YES

D. If YES, do you know the ACTG number?
○ NO (GO TO F) ○ YES

E. 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)

F. Are you currently taking this drug <u>as part of the research study</u>?
○ NO ○ YES

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

G. [Since your last visit] In what month and year did you most recently take this drug <u>as part of the research study</u>?

	YEAR
○ Jan	
○ Feb	
○ Mar	89
○ Apr	90
○ May	91
○ June	92
○ July	93
○ Aug	94
○ Sept	95
○ Oct	96
○ Nov	97
○ Dec	

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)

3. [Since your last visit] In what month and year did you most recently take this drug?

	YEAR
○ Jan	
○ Feb	
○ Mar	89
○ Apr	90
○ May	91
○ June	92
○ July	93
○ Aug	94
○ Sept	95
○ Oct	96
○ Nov	97
○ Dec	

4. Did you <u>start</u> taking this drug since your last visit?
○ NO (GO TO Q6) ○ YES

5. [Since your last visit] In what month and year did you start taking this drug?

	YEAR
○ Jan	
○ Feb	
○ Mar	89
○ Apr	90
○ May	91
○ June	92
○ July	93
○ Aug	94
○ Sept	95
○ Oct	96
○ Nov	97
○ Dec	

Please continue on the other side.

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6. **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

7. **Did you alternate your use of this drug with another anti-viral drug?**
   ◯ NO (GO TO Q9) ◯ YES

8. **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 Q12)

9. **Did you stop altogether or decrease your daily dose of (DRUG) since your last visit?**
   ◯ NO (GO TO Q12) ◯ YES

10. **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) _____

11. **Did you restart or increase your use of this drug?**
    ◯ NO ◯ YES

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

TOTAL DAILY DOSE				UNITS CODE		(RECORD PARTICIPANT'S COMPLETE RESPONSE)
						◯ Don't Know
0	0	0	0	0	0	
1000	100	10	1	10	1	
2000	200	20	2	20	2	
3000	300	30	3	30	3	
4000	400	40	4	40	4	
5000	500	50	5	50	5	
6000	600	60	6	60	6	
7000	700	70	7	70	7	
8000	800	80	8	80	8	
9000	900	90	9	90	9	

13. **Since your last visit, did you take this drug on the same day as another anti-viral drug?**
    ◯ NO ◯ YES