31 FORM 1—ANTI-VIRAL DRUGS

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

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

- ○ 3-TC (Epivir, Lamivudine)
- ○ Abacavir (Ziagen)
- ○ Adefovir (Preveon)
- ○ Amprenavir
- ○ AZT (Retrovir, Zidovudine)
- ○ Combivir (AZT & 3-TC)
- ○ d4T (Zerit, Stavudine)
- ○ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ○ ddI (dideoxyinosine, Didanosine, Videx)
- ○ Delavirdine (Rescriptor)
- ○ Efavirenz (Sustiva)
- ○ Indinavir (Crixivan)
- ○ Nelfinavir (Viracept)
- ○ Nevirapine (Viramune)
- ○ Ritonavir (Norvir)
- ○ Saquinavir (Invirase, Fortovase)
- ○ 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) ○ 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?

F. 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.

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

	YEAR
○ Jan	
○ Feb	
○ Mar	90
○ Apr	91
○ May	92
○ June	93
○ July	94
○ Aug	95
○ Sept	96
○ Oct	97
○ Nov	98
○ Dec	99

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	90
○ Apr	91
○ May	92
○ June	93
○ July	94
○ Aug	95
○ Sept	96
○ Oct	97
○ Nov	98
○ Dec	99

4. Did you start 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	90
○ Apr	91
○ May	92
○ June	93
○ July	94
○ Aug	95
○ Sept	96
○ Oct	97
○ Nov	98
○ Dec	99

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. **Have you experienced any of the following side effects from 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
- ◯ Fat maldistribution
- ◯ Other, specify:

1) _____

2) _____

3) _____

8. **Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]**

◯ NO (GO TO Q10) ◯ YES

9. **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
- ◯ Fat maldistribution

- ◯ 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)
- ◯ Other, specify:

1) _____

2) _____

3) _____

10. **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