

# 32 FORM 1—ANTI-VIRAL DRUGS

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

- |   |  |
|---|--|
| <input type="radio"/> 3-TC (Epidur, Lamivudine)                 | <input type="radio"/> Delavirdine (Rescriptor)         |
| <input type="radio"/> Abacavir (Ziagen)                         | <input type="radio"/> Efavirenz (Sustiva)              |
| <input type="radio"/> Adefovir (Preveon)                        | <input type="radio"/> Indinavir (Crixivan)             |
| <input type="radio"/> Amprenavir                                | <input type="radio"/> Nelfinavir (Viracept)            |
| <input type="radio"/> AZT (Retrovir, Zidovudine)                | <input type="radio"/> Nevirapine (Viramune)            |
| <input type="radio"/> Combivir (AZT & 3-TC)                     | <input type="radio"/> Ritonavir (Norvir)               |
| <input type="radio"/> ddC (dideoxycytidine, HIVID, Zalcitabine) | <input type="radio"/> Saquinavir (Invirase, Fortovase) |
| <input type="radio"/> ddI (dideoxyinosine, Didanosine, Videx)   | <input type="radio"/> Other                            |

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

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

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 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?

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

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?

MONTH	YEAR
Jan	
Feb	
Mar	
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?

MONTH	YEAR
Jan	
Feb	
Mar	
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.

Please continue on the other side.

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) \_\_\_\_\_

☐ None of the above

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