

34 FORM 1—ANTI-VIRAL DRUGS

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

- | | |
|---|--|
| <input type="radio"/> 3-TC (Epiriv, 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 (Agenerase) | <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"/> d4T (Zerit, Stavudine) | <input type="radio"/> Saquinavir (Invirase, Fortovase) |
| <input type="radio"/> ddC (dideoxycytidine, HIVID, Zalcitabine) | <input type="radio"/> Other |
| <input type="radio"/> ddI (dideoxyinosine, Didanosine, Videx) | |

ID Number

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

Visit No.

0	0
1	1
2	2
3	3
4	4
5	5
6	6
7	7
8	8
9	9

DATE

	DAY	YEAR
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	0	0
<input type="radio"/> Apr	10	1
<input type="radio"/> May	20	2
<input type="radio"/> June	30	3
<input type="radio"/> July	4	00
<input type="radio"/> Aug	5	01
<input type="radio"/> Sept	6	
<input type="radio"/> Oct	7	
<input type="radio"/> Nov	8	
<input type="radio"/> Dec	9	

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 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
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	92
<input type="radio"/> Apr	93
<input type="radio"/> May	94
<input type="radio"/> June	95
<input type="radio"/> July	96
<input type="radio"/> Aug	97
<input type="radio"/> Sept	98
<input type="radio"/> Oct	99
<input type="radio"/> Nov	00
<input type="radio"/> Dec	01

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)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

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

	YEAR
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	92
<input type="radio"/> Apr	93
<input type="radio"/> May	94
<input type="radio"/> June	95
<input type="radio"/> July	96
<input type="radio"/> Aug	97
<input type="radio"/> Sept	98
<input type="radio"/> Oct	99
<input type="radio"/> Nov	00
<input type="radio"/> Dec	01

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
<input type="radio"/> Jan	
<input type="radio"/> Feb	
<input type="radio"/> Mar	92
<input type="radio"/> Apr	93
<input type="radio"/> May	94
<input type="radio"/> June	95
<input type="radio"/> July	96
<input type="radio"/> Aug	97
<input type="radio"/> Sept	98
<input type="radio"/> Oct	99
<input type="radio"/> Nov	00
<input type="radio"/> Dec	01

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
☐ Nightmares/Vivid dreams
☐ Liver toxicity (abnormal liver function test)
☐ 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
☐ Nightmares/Vivid dreams
☐ Liver toxicity (abnormal liver function test)
☐ 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)
☐ Changed to another drug in order to decrease the number of pills or dosing frequency
☐ 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