36 FORM 1—ANTI-VIRAL DRUGS

ID Number | **Visit No.** | **DATE** (Day / Year)

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 15.B(3).

- ○ 3-TC (Epivir, Lamivudine)
- ○ Abacavir (Ziagen)
- ○ Amprenavir (Agenerase)
- ○ AZT (Retrovir, Zidovudine)
- ○ Atazanavir (BMS-232632)
- ○ Combivir (AZT & 3-TC)
- ○ d4T (Zerit, Stavudine)
- ○ ddC (dideoxycytidine, HIVID, Zalcitabine)
- ○ ddI (dideoxyinosine, Didanosine, Videx)
- ○ Delavirdine (Rescriptor)
- ○ Efavirenz (Sustiva)
- ○ Indinavir (Crixivan)
- ○ Lopinavir/r (Kaletra)
- ○ Nelfinavir (Viracept)
- ○ Nevirapine (Viramune)
- ○ Ritonavir (Norvir)
- ○ Saquinavir (Invirase, Fortovase)
- ○ Tenofovir
- ○ Trizivir (abacavir + zidovudine + lamivudine)
- ○ T-20
- ○ 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 ○ DON'T KNOW
○ YES

D. 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.

E. [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	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

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)

<u>IF YES</u>, 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
○ Jan	
○ Feb	
○ Mar	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

4. According to your doctor, how many times a day should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

1 2 3 4 5 6 7

5. According to your doctor, how many pills should you take each time?

1 2 3 4 5 6 7

Please continue on the other side.

6. **Did you start taking this drug since your last visit?**
   ○ NO (GO TO Q8) ○ YES

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

	YEAR
○ Jan	
○ Feb	
○ Mar	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

8. **Since your last visit in (MONTH), how long have you used (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

9. **Have you experienced any of the following side effects while taking (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
   ○ Abnormal changes in body fat
   ○ Vivid nightmares or dreams
   ○ Liver toxicity (abnormal liver function test)
   ○ Insomnia or problems sleeping
   ○ Other, specify:

   1) _____
   2) _____
   3) _____

   ○ None of the above

10. **Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]**
    ○ NO (GO TO Q12) ○ YES

11. **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
    ○ Abnormal changes in body fat
    ○ Vivid nightmares or dreams
    ○ Liver toxicity (abnormal liver function test)
    ○ Insomnia or problems sleeping
    ○ 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) _____

12. **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