FORM 1—ANTI-VIRAL DRUGS 36 **ID Number** Visit No. DATE YEAR Jan DAY COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN O Feb 0000 0 0 QUESTION 15.B(3). 11111 (1)(1) Mar 0 0 2 2 2 2 2 2 2 10 (1 O Apr 3 3 3 3 3 3-TC (Epivir, Lamivudine) Indinavir (Crixivan) 3 3 3 O May 20 2 O Lopinavir/r (Kaletra) 4 4 4 4 4 Abacavir (Ziagen) 4 4 June 30 3 4 Amprenavir (Agenerase) Nelfinavir (Viracept) 5 5 5 5 5 5 01 O July AZT (Retrovir, Zidovudine) Nevirapine (Viramune) 6 6 6 6 6 6 Aug (5) 02 7777 7 7 Atazanavir (BMS-232632) Ritonavir (Norvir) Sept 6 Combivir (AZT & 3-TC) Saquinavir (Invirase, Fortovase) 8 8 8 8 8 8 Oct (7) Od4T (Zerit, Stavudine) Tenofovir 9999 9 9 8 Nov ddC (dideoxycytidine, HIVID, Zalcitabine) Trizivir (abacavir + zidovudine + (9) Dec ddI (dideoxyinosine, Didanosine, Videx) lamivudine) Delavirdine (Rescriptor) Name of Drug: **Drug Code** Efavirenz (Sustiva) Other -0 100 200 300 400 500 600 700 800 900 0 10 20 30 40 50 60 70 80 90 You said you were taking (DRUG) since your last visit: 0 1 2 3 4 5 6 7 8 9 1.A. Did you take this drug as part of a research study? 2. Are you currently taking this drug [not as part of a O NO (GO TO Q2) YES research study]? YES (GO TO Q4) B. Was this study one in which you may have taken a ONO placebo (not the actual drug) or in which you were IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS blinded to the treatment? PART OF A TRIAL, REMEMBER TO COMPLETE A ONO O YES SECOND DRUG FORM. C. Was this part of the AIDS Clinical Trial Group (ACTG)? 3. [Since your last visit] In what month and year did you most recently take this drug? O DON'T KNOW YES) Jan YEAR ○ Feb D. Are you currently taking this drug as part of the O Mar 93 research study? 94 O Apr O YES 95 ONO May June 96 IF YES: STOP IF PARTICIPANT WAS BLINDED TO O July 97 THE TREATMENT; IF UNBLINDED, SKIP TO Q4. 98 O Aug E. [Since your last visit] In what month and year O Sept 99 did you most recently take this drug as part of (00) Oct the research study? YEAR Jan O Nov (01) Feb 02) Dec 93 Mar O Apr 94 4. According to your doctor, how many times a day 95 May should you take (DRUG)? [IF NOT CURRENTLY June 96 TAKING DRUG, USE MOST RECENT TIME! 97 July 98 O Aug 99 1 2 3 4 5 6 7 Sept 00 Oct) Nov 01 5. According to your doctor, how many pills should you 02 Dec take each time? 1 2 3 4 5 6 7

STOP IF PARTICIPANT WAS BLINDED TO

THE TREATMENT AND GO TO NEXT DRUG.

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Please continue on the other side.

6.	Did you start taking this drug since your last visit? NO (GO TO Q8) YES	10. Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]
	[Since your last visit] In what month and year did you	○ NO (GO TO Q12) ○ YES
	start taking this drug?	
	○ Jan YEAR	
	○ Feb	
	Mar 93	
	O Apr 94	11. Why did you stop taking this drug?
	May 95	(MARK ALL THAT APPLY)
	June 6	
	O July 9	Low white blood cells (low neutrophils)
	Aug 98	Anemia (low red blood cells/low hemoglobin)
	○ Sept 99 ○ Oct 99	Bleeding District on the second seco
		Dizziness/Headaches
		Nausea/Vomiting
	Oec 02	Abdominal pain (pancreatitis/abdominal bloating/cramps)
_		Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
	Since your last visit in (MONTH), how long have you	Burning/tingling in extremities
	used (DRUG)?	(neuropathy/neuritis/numbness)
	One week or less	Diarrhea Control of the Control of t
	More than 1 week but less than 1 month	Kidney stones
	1–2 months	Rash
	○ 3–4 months ○ 5–6 months	High blood sugar/Diabetes
	More than 6 months	High cholesterol/High triglycerides Painful urination
	More than o months	High blood pressure
		Abnormal changes in body fat
9.	Have you experienced any of the following side effects	Vivid nightmares or dreams
	while taking (DRUG)?	Liver toxicity (abnormal liver function test)
	(MARK ALL THAT APPLY)	Insomnia or problems sleeping
	Low white blood cells (low neutrophils)	○ Increased viral load
	Anemia (low red blood cells/low hemoglobin)	O Decreased viral load
	Bleeding	Hospitalized
	O Dizziness/Headaches	O Personal decision
	O Nausea/Vomiting	Prescription changes by physician
	Abdominal pain (pancreatitis/abdominal bloating/cramps)	○ Too expensive
	Muscle pain or weakness (myopathy/myositis/muscle	 Too much bother, inconvenient (ran out/vacation/unable
	cramps/spasms)	to fill prescription)
	Burning/tingling in extremities	Changed to another drug in order to decrease the
	(neuropathy/neuritis/numbness)	number of pills or dosing frequency
	O Diarrhea	Other, specify:
	Cidney stones	
	○ Rash	1)
	High blood sugar/Diabetes	2)
	High cholesterol/High triglycerides	
	Painful urination	3)
	○ High blood pressure○ Abnormal changes in body fat	
	○ Vivid nightmares or dreams	
	Liver toxicity (abnormal liver function test)	
	Insomnia or problems sleeping	12. On average, how often did you take your medication
	Other, specify:	as prescribed?
	Carlot, opposity.	100% of the time
	1)	95–99% of the time
		75–94% of the time
	2)	75 94% of the time
	3)	

O None of the above