46 FORM 1—ANTIRETROVIRAL DRUGS

ID Number

Visit No. 4 6 0

DATE

	DAY	YEAR
Jan		
Feb		
Mar	0 0	00
Apr	10 1	01
May	20 2	02
June	30 3	03
July	4	04
Aug	5	05
Sept	6	06
Oct	7	07
Nov	8	08
Dec	9	09

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

- ◯ abacavir (Ziagen) (**218**)
- ◯ amprenavir (Agenerase) (**219**)
- ◯ atazanavir (Reyataz) (**243**)
- ◯ Combivir (zidovudine & lamivudine) (**227**)
- ◯ d4T (Zerit, Stavudine) (**159**)
- ◯ delavirdine (Rescriptor) (**194**)
- ◯ didanosine (Videx) (**147**)
- ◯ efavirenz (Sustiva) (**220**)
- ◯ emtricitabine (Emtriva, FTC) (**239**)
- ◯ enfuvirtide (Fuzeon, T-20, pentafuside) (**233**)
- ◯ Epzicom (abacavir, lamivudine) (**254**)
- ◯ fosamprenavir (Lexiva) (**249**)
- ◯ indinavir (Crixivan) (**212**)
- ◯ lamivudine (Epivir, 3TC) (**204**)
- ◯ lopinavir (Kaletra) (**217**)
- ◯ nelfinavir (Viracept) (**216**)
- ◯ nevirapine (Viramune) (**191**)
- ◯ ritonavir (Norvir) (**211**)
- ◯ saquinavir (Invirase, Fortovase) (**210**)
- ◯ tenofovir (Viread) (**234**)
- ◯ tipranavir (**238**)
- ◯ Trizivir (abacavir + lamivudine + zidovudine) (**240**)
- ◯ Truvada (emtricitabine + tenofovir) (**253**)
- ◯ zidovudine (Retrovir, AZT) (**092**)
- ◯ Other → 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) study?

◯ NO ◯ DON'T KNOW
◯ YES

D. Are you currently taking this drug as part of the research study?

◯ NO (GO TO E.) ◯ YES STOP, IF BLINDED. GO TO Q4, IF UNBLINDED.

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

J F M A M J J A S O N D
97 98 99 00 01 02 03 04 05 06 07 08

IF BLINDED, STOP. GO TO NEXT DRUG.
IF UNBLINDED, GO TO Q2.

2. Are you currently taking this drug [not as part of a research study]?

◯ NO (GO TO Q3) ◯ YES (GO TO Q4)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A STUDY, YOU MUST COMPLETE THIS FORM FOR RESEARCH USE AND **COMPLETE ANOTHER FORM FOR NON-RESEARCH DRUG USE**.

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

J F M A M J J A S O N D
97 98 99 00 01 02 03 04 05 06 07 08

4. Do you take this drug by mouth or receive it by injection?

◯ by mouth (pill)
◯ injection

IF BY INJECTION, SKIP TO Q7.

5. According to your doctor, how many times per day, week, or month should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

NUMBER OF TIMES PER ◯ Day or ◯ Week or ◯ Month

0 10 20 30
0 1 2 3 4 5 6 7 8 9

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

1 2 3 4 5 6 7 8 9 10

IF BY MOUTH, SKIP TO Q8.

7. How many times per day, week, or month do you inject this drug?

NUMBER OF TIMES PER ◯ Day or ◯ Week or ◯ Month

0 10 20 30
0 1 2 3 4 5 6 7 8 9

Please continue on the other side.

CC#4

8. Did you start taking this drug since your last visit?

◯ NO (GO TO Q10) ◯ YES

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

	J	F	M	A	M	J	J	A	S	O	N	D
	97	98	99	00	01	02	03	04	05	06	07	08

10. 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 (includes 2 months and longer, but less than 3 months)
◯ 3–4 months (includes 4 months and longer, but less than 5 months)
◯ 5–6 months
◯ More than 6 months

11. Did you stop taking this drug, for 2 days or longer, at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]

◯ NO (GO TO Q13) ◯ YES

12. Why did you stop taking this drug? (MARK ALL THAT APPLY)

◯ Low white blood cells (low neutrophils)
◯ Anemia (low red blood cells/low hemoglobin)
◯ Blood in urine
◯ Bleeding
◯ Dizziness/Headaches
◯ Nausea/Vomiting
◯ Abdominal pain (pancreatitis/abdominal bloating/cramps)
◯ Diarrhea
◯ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
◯ Burning/tingling in extremities (neuropathy/neuritis/numbness)
◯ Kidney stones
◯ Kidney failure
◯ 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
◯ Fatigue
◯ 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
◯ Study ended
◯ Other, specify:

1) _____
2) _____
3) _____

13. 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