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# FORM 2 – NON-ANTI-VIRAL DRUGS

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 11.B.(2).

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

ID Number

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

Visit No.

	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

Date

<input type="radio"/> Jan	DAY	YEAR
<input type="radio"/> Feb		
<input type="radio"/> Mar	0 0	90
<input type="radio"/> Apr	10 1	91
<input type="radio"/> May	20 2	
<input type="radio"/> Jun	30 3	
<input type="radio"/> Jul	4	
<input type="radio"/> Aug	5	
<input type="radio"/> Sep	6	
<input type="radio"/> Oct	7	
<input type="radio"/> Nov	8	
<input type="radio"/> Dec	9	

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

1. A. Did you take this drug as part of a research study in which you may have taken a placebo (not the actual drug) or in which you were blinded to the treatment?

- NO (GO TO Q2)
- YES

B. Was this part of the AIDS Clinical Trial Group (ACTG)?

- NO (STOP, GO TO NEXT DRUG)
- YES
- DON'T KNOW (STOP, GO TO NEXT DRUG)

C. If YES, do you know the ACTG number?

- NO (STOP, GO TO NEXT DRUG)
- YES

D. 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

**STOP, GO TO THE NEXT DRUG.**

2. When did you first start taking this drug?

<input type="radio"/> Jan	DAY	YEAR
<input type="radio"/> Feb		
<input type="radio"/> Mar	0 0	82
<input type="radio"/> Apr	10 1	83
<input type="radio"/> May	20 2	84
<input type="radio"/> Jun	30 3	85
<input type="radio"/> Jul	4	86
<input type="radio"/> Aug	5	87
<input type="radio"/> Sep	6	88
<input type="radio"/> Oct	7	89
<input type="radio"/> Nov	8	90
<input type="radio"/> Dec	9	91

(USE "15" FOR DAY IF PARTICIPANT DOES NOT KNOW ACTUAL DAY)

3. How often did you take this drug?

(RECORD IN NUMBER OF TIMES PER DAY OR TIMES PER WEEK OR TIMES PER MONTH)

NUMBER OF TIMES

	0	0
	10	1
	20	2
	30	3
	40	4
	50	5
	60	6
	70	7
	80	8
	90	9

PER

- Day or
- Week or
- Month

Don't Know

4. How many (days, weeks, months) did you use (DRUG) since your last visit?

	0	0	0
	100	10	1
	200	20	2
	300	30	3
	400	40	4
	500	50	5
	600	60	6
	700	70	7
	800	80	8
	900	90	9

- Days or
- Weeks or
- Months

Don't Know

5. Are you currently taking this drug?

- NO
- YES