

FORM 1—ANTIRETROVIRAL DRUGS

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

- abacavir (Ziagen) (218)
- atazanavir (Reyataz) (243)
- Atripla (efavirenz + emtricitabine + tenofovir) (262)
- Combivir (zidovudine & lamivudine) (227)
- d4T (Zerit, Stavudine) (159)
- darunavir (Prezista) (256)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- Epzicom (abacavir + lamivudine) (254)
- Etravirine (Intelence, TMC-125) (255)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- lamivudine (EpiVir, 3TC) (204)
- lopinavir/ritonavir (Kaletra, LPV) (217)
- nelfinavir (Viracept) (216)
- nevirapine (Viramune) (191)
- Raltegravir (Isentress) (264)
- ritonavir (Norvir) (211)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Truvada (emtricitabine + tenofovir) (253)
- zidovudine (Retrovir, AZT) (092)
- Other →

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

| | | |
|----------------------------|------|------|
| <input type="radio"/> Jan | DAY | YEAR |
| <input type="radio"/> Feb | | |
| <input type="radio"/> Mar | 0 0 | 09 |
| <input type="radio"/> Apr | 10 1 | 10 |
| <input type="radio"/> May | 20 2 | 11 |
| <input type="radio"/> June | 30 3 | 12 |
| <input type="radio"/> July | 4 | 13 |
| <input type="radio"/> Aug | 5 | 14 |
| <input type="radio"/> Sept | 6 | 15 |
| <input type="radio"/> Oct | 7 | 16 |
| <input type="radio"/> Nov | 8 | 17 |
| <input type="radio"/> Dec | 9 | 18 |

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 |

Name of Drug:

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 |
| 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 |

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 |
| 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 |

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

- by mouth (pill or liquid)
 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 or doses 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.

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 |
| | 01 | 02 | 03 | 04 | 05 | 06 | 07 | 08 | 09 | 10 | 11 | 12 |

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