

39 FORM 1—ANTI-VIRAL DRUGS

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

- | | |
|---|---|
| <input type="radio"/> 3-TC (Epiriv, Lamivudine) | <input type="radio"/> Indinavir (Crixivan) |
| <input type="radio"/> Abacavir (Ziagen) | <input type="radio"/> Lopinavir/r (Kaletra) |
| <input type="radio"/> Amprenavir (Agenerase) | <input type="radio"/> Nelfinavir (Viracept) |
| <input type="radio"/> AZT (Retrovir, Zidovudine) | <input type="radio"/> Nevirapine (Viramune) |
| <input type="radio"/> Atazanavir (BMS-232632) | <input type="radio"/> Ritonavir (Norvir) |
| <input type="radio"/> Combivir (AZT & 3-TC) | <input type="radio"/> Saquinavir (Invirase, Fortovase) |
| <input type="radio"/> d4T (Zerit, Stavudine) | <input type="radio"/> Tenofovir (Viread) |
| <input type="radio"/> ddC (Dideoxycytidine, HIVID, Zalcitabine) | <input type="radio"/> Trizivir (Abacavir + Zidovudine + Lamivudine) |
| <input type="radio"/> ddI (Dideoxyinosine, Didanosine, Videx) | <input type="radio"/> T-20 |
| <input type="radio"/> Delavirdine (Rescriptor) | <input type="radio"/> Other → |
| <input type="radio"/> Efavirenz (Sustiva) | |

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 RESF1_##

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 PLCF1_##

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

NO DON'T KNOW ACTF1_##
 YES

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

NO YES RNWF1_##

IF YES: 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 as part of the research study?

J	F	M	A	M	J	J	A	S	O	N	D
92	93	94	95	96	97	98	99	00	01	02	03

AVRSM_##
AVRSY_##

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) AVNW_##

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

ID Number	Visit No.	DATE
MACSID	VISIT_##	<input type="radio"/> Jan DAY YEAR <input type="radio"/> Feb <input type="radio"/> Mar <input type="radio"/> Apr <input type="radio"/> May <input type="radio"/> June <input type="radio"/> July <input type="radio"/> Aug <input type="radio"/> Sept <input type="radio"/> Oct <input type="radio"/> Nov <input type="radio"/> Dec
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	2 2 3 3 3 4 4 5 5 6 6 7 7 8 8 9 9	AVQM_## AVQD_## AVQY_##

Name of Drug:

DRGAV_##

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

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
92	93	94	95	96	97	98	99	00	01	02	03

AVRM_##
AVRY_##

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

pill
 injection

DORIN_##

IF BY INJECTION, SKIP TO Q7.

5. 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
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PRES1_##

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

1	2	3	4	5	6	7	8	9	10
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NPILT_##

IF BY PILL, SKIP TO Q8.

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

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

TINJD_##

PER Day
or
 Week
or
 Month

INJDU_##

Please continue on the other side.

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

NO (GO TO Q10) YES START_##

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
	92	93	94	95	96	97	98	99	00	01	02	03

AVSM_##
AVSY_##

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

LENV_##

11. Have you experienced any of the following side effects while taking (DRUG)?

(MARK ALL THAT APPLY)

- Low white blood cells (low neutrophils) SEWBC_##
 Anemia (low red blood cells/low hemoglobin) SEANE_##
 Blood in urine SEBLU_##
 Bleeding SEBLD_##
 Dizziness/Headaches SEHED_##
 Nausea/Vomiting SEVOT_##
 Abdominal pain (pancreatitis/abdominal bloating) SEABP_##
 Muscle pain or weakness (myopathy/myositis/cramps/spasms) SEMPW_##
 Burning/tingling in extremities (neuropathy/neuritis/numbness) SEBTE_##
 Diarrhea SEDIA_##
 Kidney stones SEKID_##
 Renal failure SEREN_##
 Rash SERAS_##
 High blood sugar/Diabetes SEDM_##
 High cholesterol/High triglycerides SECHO_##
 Painful urination SEURN_##
 High blood pressure SEHBP_##
 Abnormal changes in body fat SEFAT_##
 Vivid nightmares or dreams SENVD_##
 Liver toxicity (abnormal liver function test) SELTX_##
 Insomnia or problems sleeping SEIPS_##
 Other, specify:

1) — SEOT1_##
 2) — SEOT2_##
 3) — SEOT3_##

None of the above SENOA_##

12. Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]

NO (GO TO Q14) YES DECAV_##

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

- Low white blood cells (low neutrophils) STWBC_##
 Anemia (low red blood cells/low hemoglobin) STANE_##
 Blood in urine STBLU_##
 Bleeding STBLD_##
 Dizziness/Headaches STHED_##
 Nausea/Vomiting STVOT_##
 Abdominal pain (pancreatitis/abdominal bloating) STABP_##
 Muscle pain or weakness (myopathy/myositis/cramps/spasms) STMPW_##
 Burning/tingling in extremities (neuropathy/neuritis/numbness) STBTE_##
 Diarrhea STDIA_##
 Kidney stones STKID_##
 Renal failure STREN_##
 Rash STRAS_##
 High blood sugar/Diabetes STDM_##
 High cholesterol/High triglycerides STCHO_##
 Painful urination STURN_##
 High blood pressure STHBP_##
 Abnormal changes in body fat STFAT_##
 Vivid nightmares or dreams STNVD_##
 Liver toxicity (abnormal liver function test) STLTX_##
 Insomnia or problems sleeping STIPS_##
 Increased viral load SINVL_##
 Decreased viral load SDCVL_##
 Hospitalized STHOS_##
 Personal decision STPER_##
 Prescription changes by physician STDOC_##
 Too expensive STEXP_##
 Too much bother, inconvenient (ran out/vacation to fill prescription) STINC_##
 Changed to another drug in order to decrease the number of pills or dosing frequency STCGD_##
 Other, specify:

1) — STOT1_##
 2) — STOT2_##
 3) — STOT3_##

14. On average, how often did you take your medication as prescribed?

- 100% of the time MDPRE_##
 95–99% of the time
 75–94% of the time
 <75% of the time