40 FORM 1—ANTI-VIRAL DRUGS

ID Number: MACSID
Visit No.: 4 0 0 — VISIT_40
DATE: Jan, Feb, Mar, Apr, M, J, J, Aug, Sept, Oct, Nov, Dec — DAY, YEAR — AVQM_40, AVQD_40, AVQY_40

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

- ◯ 3-TC (Epivir, Lamivudine)
- ◯ Abacavir (Ziagen)
- ◯ Amprenavir (Agenerase)
- ◯ AZT (Retrovir, Zidovudine)
- ◯ Atazanavir (Reyataz, BMS-232632)
- ◯ Combivir (AZT & 3-TC)
- ◯ d4T (Zerit, Stavudine)
- ◯ ddC (Dideoxycytidine, HIVID, Zalcitabine)
- ◯ ddI (Dideoxyinosine, Didanosine, Videx)
- ◯ Delavirdine (Rescriptor)
- ◯ Efavirenz (Sustiva)
- ◯ Emtriva (Emtricitabine)
- ◯ Fuzeon (Pentafuside, Efuvirtude, T-20)
- ◯ Indinavir (Crixivan)
- ◯ Lopinavir/r (Kaletra)
- ◯ Nelfinavir (Viracept)
- ◯ Nevirapine (Viramune)
- ◯ Ritonavir (Norvir)
- ◯ Saquinavir (Invirase, Fortovase)
- ◯ Tenofovir (Viread)
- ◯ Trizivir (Abacavir + Zidovudine + Lamivudine)
- ◯ Other → Name of Drug: → Drug Code — DRGAV_40

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_40

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_40

C. Was this part of the AIDS Clinical Trial Group (ACTG)?
◯ NO ◯ DON'T KNOW ◯ YES — ACTF1_40

D. Are you currently taking this drug as part of the research study?
◯ NO ◯ YES — RNWF1_40

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? — AVRSM_40, AVRSY_40
J F M A M J J A S O N D
92 93 94 95 96 97 98 99 00 01 02 03

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_40

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

3. [Since your last visit] In what month and year did you most recently take this drug? — AVRM_40, AVRY_40
J F M A M J J A S O N D
92 93 94 95 96 97 98 99 00 01 02 03

4. Do you take this drug orally by pill or receive it by injection? — DORIN_40
◯ 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 (0 10 20 30 / 0 1 2 3 4 5 6 7 8 9) — PRES1_40, PREST_40
PER ◯ Day or ◯ Week or ◯ Month

6. According to your doctor, how many pills should you take each time? — NPILT_40
1 2 3 4 5 6 7 8 9 10
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_40, INJDU_40
PER ◯ Day or ◯ Week or ◯ Month

Please continue on the other side.

8. **Did you start taking this drug since your last visit?**
◯ NO (GO TO Q10) ◯ YES **START_40**

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_40
AVSY_40

10. **Since your last visit in (MONTH), how long have you used (DRUG)?** **LENAV_40**
◯ 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. **Have you experienced any of the following side effects while taking (DRUG)? (MARK ALL THAT APPLY)**
◯ Low white blood cells (low neutrophils) **SEWBC_40**
◯ Anemia (low red blood cells/low hemoglobin) **SEANE_40**
◯ Blood in urine **SEBLU_40**
◯ Bleeding **SEBLD_40**
◯ Dizziness/Headaches **SEHED_40**
◯ Nausea/Vomiting **SEVOT_40**
◯ Abdominal pain (pancreatitis/abdominal bloati **SEABP_40**
◯ Muscle pain or weakness (myopathy/myositis/ **SEMPW_40**
cramps/spasms)
◯ Burning/tingling in extremities **SEBTE_40**
(neuropathy/neuritis/numbness)
◯ Diarrhea **SEDIA_40**
◯ Kidney stones **SEKID_40**
◯ Renal failure **SEREN_40**
◯ Rash **SERAS_40**
◯ High blood sugar/Diabetes **SEDM_40**
◯ High cholesterol/High triglycerides **SECHO_40**
◯ Painful urination **SEURN_40**
◯ High blood pressure **SEHBP_40**
◯ Abnormal changes in body fat **SEFAT_40**
◯ Vivid nightmares or dreams **SENVD_40**
◯ Liver toxicity (abnormal liver function test) **SELTX_40**
◯ Insomnia or problems sleeping **SEIPS_40**
◯ Other, specify:

1) ________ **SEOT1_40** ________
2) ________ **SEOT2_40** ________
3) ________ **SEOT3_40**

◯ None of the above
SENOA_40

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_40**

13. **Why did you stop taking this drug? (MARK ALL THAT APPLY)**
◯ Low white blood cells (low neutrophils) **STWBC_40**
◯ Anemia (low red blood cells/low hemoglobin) **STANE_40**
◯ Blood in urine **STBLU_40**
◯ Bleeding **STBLD_40**
◯ Dizziness/Headaches **STHED_40**
◯ Nausea/Vomiting **STVOT_40**
◯ Abdominal pain (pancreatitis/abdominal bloating/cra **STABP_40**
◯ Muscle pain or weakness (myopathy/myositis/musc **STMPW_40**
cramps/spasms)
◯ Burning/tingling in extremities **STBTE_40**
(neuropathy/neuritis/numbness)
◯ Diarrhea **STDIA_40**
◯ Kidney stones **STKID_40**
◯ Renal failure **STREN_40**
◯ Rash **STRAS_40**
◯ High blood sugar/Diabetes **STDM_40**
◯ High cholesterol/High triglycerides **STCHO_40**
◯ Painful urination **STURN_40**
◯ High blood pressure **STHBP_40**
◯ Abnormal changes in body fat **STFAT_40**
◯ Vivid nightmares or dreams **STNVD_40**
◯ Liver toxicity (abnormal liver function test) **STLTX_40**
◯ Insomnia or problems sleeping **STIPS_40**
◯ Increased viral load **SINVL_40**
◯ Decreased viral load **SDCVL_40**
◯ Hospitalized **STHOS_40**
◯ Personal decision **STPER_40**
◯ Prescription changes by physician **STDOC_40**
◯ Too expensive **STEXP_40**
◯ Too much bother, inconvenient (ran out/vacation/un **STINC_40**
to fill prescription)
◯ Changed to another drug in order to decrease the number of pills or dosing frequency **STCGD_40**
◯ Other, specify:

1) ________ **STOT1_40** ________
2) ________ **STOT2_40** ________
3) ________ **STOT3_40**

14. **On average, how often did you take your medication as prescribed?** **MDPRE_40**
◯ 100% of the time
◯ 95–99% of the time
◯ 75–94% of the time
◯ <75% of the time