50 FORM 1—ANTIRETROVIRAL DRUGS

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

1. Did you take this drug as part of a research study?
   - NO (GO TO Q2)
   - YES

2. Are you currently taking this drug (not as part of a research study)?
   - NO (GO TO Q3)
   - YES (GO TO Q4)

3. Since your last visit, in what month and year did you most recently take this drug?

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]
   - Day
   - Week
   - Month

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

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

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