**51 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)
- delavirdine (Rescriptor) (194)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- enfuvirtide (Fuzeon, T-20, pentafuside) (233)
- Epzicom (abacavir + lamivudine) (254)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)

**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

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

**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.

**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

**IF BLINDED, STOP. GO TO NEXT DRUG. IF UNBLINDED, GO TO Q2.**

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

2. **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

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]**

**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?**

**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?  


[ ] 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  
☐ 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