

MACSID: \_\_\_\_\_

Drug name: \_\_\_\_\_

Drug code: \_\_\_\_\_

*Ask the participant for the names of the antiretroviral drugs taken since last visit and fill out one form for each reported drug. If this is a person to person interview, show the drug list hand-out (Appendix 1). Identify the drug codes in the attached drop down list (Appendix 2).*

*If the participant has taken the drug both as part of a research study and not part of research study (regular prescription care under his doctor) then fill out two forms: first, for non-research use and then follow for research use.*

*Mark each bubble next to the selected response.*

1. A. Did you take (INSERT DRUG NAME) since your last visit as ...

READ EACH OPTION.
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1. Not part of a research study (non-research use only)
2. Part of a research study only
3. Both non-research and research study

*If Q1.A = 1, go to Q2 to ask about taking the drug as not part of a research study.*

*If Q1.A = 2, go to Q1.B to ask about taking the drug as part of a research study.*

*If Q1.A = 3, fill out two forms; first for non-research use, starting at Q2; then for research use start at Q1.B.*

1. 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?

1. No
2. Yes

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

1. No
2. Yes
3. Don't know

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

1. No → Go to Q1.E

2. Yes →

GO TO Q4, IF UNBLINDED (Q1.B = NO). STOP, IF BLINDED (Q1.B = YES).
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1. E. [Since your last visit], in what month and year did you most recently take this drug as part of the research study?

\_\_\_\_\_  
Month                      year

GO TO **Q2**, IF UNBLINDED (**Q1.B** = NO)  
STOP, IF BLINDED (**Q1.B** = YES).

2. Are you currently taking this drug [not as part of a research study?]

- 1. No      →    **GO TO Q3.**
- 2. Yes     →    **GO TO Q4.**

3. [Since your last visit] In what month and year did you most recently take this drug?

\_\_\_\_\_  
month                      year

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

- 1. By mouth (pill or liquid)
- 2. Injection      →    **GO 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
- Week
- Month

Select day, week or month and fill in number of times taken by mouth.

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

Number of times: \_\_\_\_\_

*If take drug by mouth, GO TO Q8*

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

**Number of times:** \_\_\_\_\_

*per....*

- Day
- Week
- Month

*Select day, week or month and fill in number of times inject drug.*

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

- 1. No     —> **GO TO Q10.**
- 2. Yes    —>

**9. [Since your last visit] In what month and year did you start taking this drug?**

\_\_\_\_\_ / \_\_\_\_\_  
*month                      year*

**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]**

- 1. No     —> **GO TO Q13.**
- 2. Yes    —>

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

<ul style="list-style-type: none"> <li><input type="checkbox"/> Low white blood cells (low neutrophils)</li> <li><input type="checkbox"/> Anemia (low red blood cells/low hemoglobin)</li> <li><input type="checkbox"/> Blood in urine</li> <li><input type="checkbox"/> Bleeding</li> <li><input type="checkbox"/> Dizziness/Headaches</li> <li><input type="checkbox"/> Nausea/Vomiting</li> <li><input type="checkbox"/> Abdominal pain (pancreatitis/abdominal bloating/cramps)</li> <li><input type="checkbox"/> Diarrhea</li> <li><input type="checkbox"/> Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)</li> <li><input type="checkbox"/> Burning/tingling in extremities (neuropathy/neuritis/numbness)</li> <li><input type="checkbox"/> Kidney stones</li> <li><input type="checkbox"/> Kidney failure</li> <li><input type="checkbox"/> Rash</li> <li><input type="checkbox"/> High blood sugar/Diabetes</li> <li><input type="checkbox"/> High cholesterol/High triglycerides</li> <li><input type="checkbox"/> Painful urination</li> <li><input type="checkbox"/> High blood pressure</li> <li><input type="checkbox"/> Abnormal changes in body fat</li> <li><input type="checkbox"/> Vivid nightmares or dreams</li> <li><input type="checkbox"/> Liver toxicity (abnormal liver function test)</li> <li><input type="checkbox"/> Insomnia or problems sleeping</li> <li><input type="checkbox"/> Fatigue</li> <li><input type="checkbox"/> Increased viral load</li> <li><input type="checkbox"/> Decreased viral load</li> <li><input type="checkbox"/> Hospitalized</li> <li><input type="checkbox"/> Personal decision</li> <li><input type="checkbox"/> Prescription changes by physician</li> <li><input type="checkbox"/> Too expensive</li> <li><input type="checkbox"/> Too much bother, inconvenient (ran out/vacation/unable to fill prescription)</li> <li><input type="checkbox"/> Changed to another drug in order to decrease the number of pills or dosing frequency</li> <li><input type="checkbox"/> Study ended</li> <li><input type="checkbox"/> Other, specify:</li> </ul>	
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**Other reasons for stopping medications:**

- 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

***Adherence questions:***

**1.a How many times did you actually take (DRUG )?**

**When referring to 2 days ago, 3 days ago, and 4 days ago, name the respective day of the week.**  
*Note: If what is actually taken is greater than prescribed dosage in the drug form, please verify.*

- Yesterday \_\_\_\_\_
- 2 days ago \_\_\_\_\_
- 3 days ago \_\_\_\_\_
- 4 days ago \_\_\_\_\_

**1.b Is this pattern typical of your recent use of [medication]?**

- 1. No
- 2. Yes
- 3. Refused

**1.c Was there any time in the last 4 days that you took fewer pills/injections per dose (time) than were prescribed?**

- 1. No
- 2. Yes
- 3. Refused