37 FORM 1—ANTI-VIRAL DRUGS

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

ID Number | Visit No. | DATE (DAY / YEAR)

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

Jan, Feb, Mar, Apr, May, June, July, Aug, Sept, Oct, Nov, Dec; 01 ○ 02 ○

Name of Drug:

Drug Code

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

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)?

○ NO ○ DON'T KNOW ○ YES

D. Are you currently taking this drug <u>as part of the research study</u>?

○ NO ○ YES

<u>IF YES</u>: 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 <u>as part of the research study</u>?

	YEAR
○ Jan	
○ Feb	
○ Mar	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

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)

<u>IF YES</u>, 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?

	YEAR
○ Jan	
○ Feb	
○ Mar	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

4. 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

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

1 2 3 4 5 6 7

Please continue on the other side.

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

○ NO (GO TO Q8) ○ YES

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

	YEAR
○ Jan	
○ Feb	
○ Mar	93
○ Apr	94
○ May	95
○ June	96
○ July	97
○ Aug	98
○ Sept	99
○ Oct	00
○ Nov	01
○ Dec	02

8. 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
- ○ 3–4 months
- ○ 5–6 months
- ○ More than 6 months

9. Have you experienced any of the following side effects while taking (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)
- ○ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
- ○ Burning/tingling in extremities (neuropathy/neuritis/numbness)
- ○ Diarrhea
- ○ Kidney stones
- ○ Renal 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
- ○ Other, specify:

1) _____

2) _____

3) _____

- ○ None of the above

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

○ NO (GO TO Q12) ○ YES

11. 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)
- ○ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
- ○ Burning/tingling in extremities (neuropathy/neuritis/numbness)
- ○ Diarrhea
- ○ Kidney stones
- ○ Renal 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
- ○ 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
- ○ Other, specify:

1) _____

2) _____

3) _____

12. 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