Effective January 2011, the variable visit number suffix was changed from 2 digits (i.e., VARIABLE_54) to a 3 digit suffix (i.e., VARIABLE_054) and affects ALL visit questionnaire variables from the first visit onward.

39 FORM 1—ANTI-VIRAL DRUGS

ID Number MACSID

Visit No. VISIT_##

DATE AVQM_## AVQD_## AVQY_##

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

- 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 →

Name of Drug: DRGAV_## →

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 RESF1_##

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_##

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

NO DON'T KNOW

YES ACTF1_##

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

NO YES RNWF1_##

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?

J F M A M J J A S O N D / 92 93 94 95 96 97 98 99 00 01 02 03

AVRSM_## AVRSY_##

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_##

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?

J F M A M J J A S O N D / 92 93 94 95 96 97 98 99 00 01 02 03

AVRM_## AVRY_##

4. Do you take this drug orally by pill or receive it by injection?

DORIN_##

- pill
- injection

IF BY INJECTION, SKIP TO Q7.

5. According to your doctor, how many times a day should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

PRES1_## 1 2 3 4 5 6 7

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

NPILT_## 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_##

PER

- Day
- or
- Week
- or
- Month

INJDU_##

Please continue on the other side.

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

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_##
AVSY_##

10. **Since your last visit in (MONTH), how long have you used (DRUG)?** **LENAV_##**
○ 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_##**
○ Anemia (low red blood cells/low hemoglobin) **SEANE_##**
○ Blood in urine **SEBLU_##**
○ Bleeding **SEBLD_##**
○ Dizziness/Headaches **SEHED_##**
○ Nausea/Vomiting **SEVOT_##**
○ Abdominal pain (pancreatitis/abdominal bloatir **SEABP_##**
○ Muscle pain or weakness (myopathy/myositis/ **SEMPW_##**
cramps/spasms)
○ Burning/tingling in extremities (neuropathy/neuritis/numbness) **SEBTE_##**
○ Diarrhea **SEDIA_##**
○ Kidney stones **SEKID_##**
○ Renal failure **SEREN_##**
○ Rash **SERAS_##**
○ High blood sugar/Diabetes **SEDM_##**
○ High cholesterol/High triglycerides **SECHO_##**
○ Painful urination **SEURN_##**
○ High blood pressure **SEHBP_##**
○ Abnormal changes in body fat **SEFAT_##**
○ Vivid nightmares or dreams **SENVD_##**
○ Liver toxicity (abnormal liver function test) **SELTX_##**
○ Insomnia or problems sleeping **SEIPS_##**
○ Other, specify:

1) _____ **SEOT1_##**
2) _____ **SEOT2_##**
3) _____ **SEOT3_##**

○ None of the above **SENOA_##**

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_##**

13. **Why did you stop taking this drug? (MARK ALL THAT APPLY)**
○ Low white blood cells (low neutrophils) **STWBC_##**
○ Anemia (low red blood cells/low hemoglobin) **STANE_##**
○ Blood in urine **STBLU_##**
○ Bleeding **STBLD_##**
○ Dizziness/Headaches **STHED_##**
○ Nausea/Vomiting **STVOT_##**
○ Abdominal pain (pancreatitis/abdominal bloating **STABP_##**
○ Muscle pain or weakness (myopathy/myositis/m **STMPW_##**
cramps/spasms)
○ Burning/tingling in extremities (neuropathy/neuritis/numbness) **STBTE_##**
○ Diarrhea **STDIA_##**
○ Kidney stones **STKID_##**
○ Renal failure **STREN_##**
○ Rash **STRAS_##**
○ High blood sugar/Diabetes **STDM_##**
○ High cholesterol/High triglycerides **STCHO_##**
○ Painful urination **STURN_##**
○ High blood pressure **STHBP_##**
○ Abnormal changes in body fat **STFAT_##**
○ Vivid nightmares or dreams **STNVD_##**
○ Liver toxicity (abnormal liver function test) **STLTX_##**
○ Insomnia or problems sleeping **STIPS_##**
○ Increased viral load **SINVL_##**
○ Decreased viral load **SDCVL_##**
○ Hospitalized **STHOS_##**
○ Personal decision **STPER_##**
○ Prescription changes by physician **STDOC_##**
○ Too expensive **STEXP_##**
○ Too much bother, inconvenient (ran out/vacation **STINC_##**
to fill prescription)
○ Changed to another drug in order to decrease th **STCGD_##**
number of pills or dosing frequency
○ Other, specify:

1) _____ **STOT1_##**
2) _____ **STOT2_##**
3) _____ **STOT3_##**

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