

40 FORM 1—ANTI-VIRAL DRUGS

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

- | | |
|---|---|
| <input type="radio"/> 3-TC (Epivir, Lamivudine) | <input type="radio"/> Fuzeon (Pentafuside, Efavirtude, T-20) |
| <input type="radio"/> Abacavir (Ziagen) | <input type="radio"/> Indinavir (Crixivan) |
| <input type="radio"/> Amprenavir (Agenerase) | <input type="radio"/> Lopinavir/r (Kaletra) |
| <input type="radio"/> AZT (Retrovir, Zidovudine) | <input type="radio"/> Nelfinavir (Viracept) |
| <input type="radio"/> Atazanavir (Reyataz, BMS-232632) | <input type="radio"/> Nevirapine (Viramune) |
| <input type="radio"/> Combivir (AZT & 3-TC) | <input type="radio"/> Ritonavir (Norvir) |
| <input type="radio"/> d4T (Zerit, Stavudine) | <input type="radio"/> Saquinavir (Invirase, Fortovase) |
| <input type="radio"/> ddC (Dideoxycytidine, HIVID, Zalcitabine) | <input type="radio"/> Tenofovir (Viread) |
| <input type="radio"/> ddI (Dideoxyinosine, Didanosine, Videx) | <input type="radio"/> Trizivir (Abacavir + Zidovudine + Lamivudine) |
| <input type="radio"/> Delavirdine (Rescriptor) | <input type="radio"/> Other → |
| <input type="radio"/> Efavirenz (Sustiva) | |
| <input type="radio"/> Emtriva (Emtricitabine) | |

ID Number

0	0	0	0
1	1	1	1
2	2	2	2
3	3	3	3
4	4	4	4
5	5	5	5
6	6	6	6
7	7	7	7
8	8	8	8
9	9	9	9

Visit No.

4	0	0
1	1	
2	2	
3	3	
4	4	
5	5	
6	6	
7	7	
8	8	
9	9	

DATE

	DAY	YEAR
<input type="radio"/> Jan		
<input type="radio"/> Feb		
<input type="radio"/> Mar	0	00
<input type="radio"/> Apr	10	01
<input type="radio"/> May	20	02
<input type="radio"/> June	30	03
<input type="radio"/> July	4	04
<input type="radio"/> Aug	5	05
<input type="radio"/> Sept	6	06
<input type="radio"/> Oct	7	07
<input type="radio"/> Nov	8	08
<input type="radio"/> Dec	9	09

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 as part of the research study?

- NO YES

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

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)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

Name of Drug:

Drug Code

	0	100	200	300	400	500	600	700	800	900
	0	10	20	30	40	50	60	70	80	90
	0	1	2	3	4	5	6	7	8	9

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

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

- pill
 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]

NUMBER OF TIMES

	0	10	20	30						
	0	1	2	3	4	5	6	7	8	9

- PER Day
 or
 Week
 or
 Month

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

1	2	3	4	5	6	7	8	9	10
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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

- PER Day
 or
 Week
 or
 Month

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?

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

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. 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

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

13. 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) _____

14. 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