Effective January 18, 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.

40 FORM 1—ANTI-VIRAL DRUGS

ID Number MACSID

Visit No. 400 VISIT_40

DATE AVQM_40 AVQD_40 AVQY_40

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

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

Name of Drug:

Drug Code DRGAV_40

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_40

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_40

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

NO DON'T KNOW ACTF1_40

YES

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

NO YES RNWF1_40

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?

AVRSM_40 AVRSY_40

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) AVNW_40

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_40 AVRY_40

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

DORIN_40

- 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

PRES1_40 PREST_40

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 NPILT_40

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_40 INJDU_40

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 **START_40**

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_40
AVSY_40

10. **Since your last visit in (MONTH), how long have you used (DRUG)?** **LENAV_40**
○ 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_40**
○ Anemia (low red blood cells/low hemoglobin) **SEANE_40**
○ Blood in urine **SEBLU_40**
○ Bleeding **SEBLD_40**
○ Dizziness/Headaches **SEHED_40**
○ Nausea/Vomiting **SEVOT_40**
○ Abdominal pain (pancreatitis/abdominal bloati **SEABP_40**
○ Muscle pain or weakness (myopathy/myositis/ **SEMPW_40**
cramps/spasms)
○ Burning/tingling in extremities **SEBTE_40**
(neuropathy/neuritis/numbness)
○ Diarrhea **SEDIA_40**
○ Kidney stones **SEKID_40**
○ Renal failure **SEREN_40**
○ Rash **SERAS_40**
○ High blood sugar/Diabetes **SEDM_40**
○ High cholesterol/High triglycerides **SECHO_40**
○ Painful urination **SEURN_40**
○ High blood pressure **SEHBP_40**
○ Abnormal changes in body fat **SEFAT_40**
○ Vivid nightmares or dreams **SENVD_40**
○ Liver toxicity (abnormal liver function test) **SELTX_40**
○ Insomnia or problems sleeping **SEIPS_40**
○ Other, specify:

1) _____ **SEOT1_40** _____
2) _____ **SEOT2_40** _____
3) _____ **SEOT3_40**

○ None of the above **SENOA_40**

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_40**

13. **Why did you stop taking this drug?**
(MARK ALL THAT APPLY)
○ Low white blood cells (low neutrophils) **STWBC_40**
○ Anemia (low red blood cells/low hemoglobin) **STANE_40**
○ Blood in urine **STBLU_40**
○ Bleeding **STBLD_40**
○ Dizziness/Headaches **STHED_40**
○ Nausea/Vomiting **STVOT_40**
○ Abdominal pain (pancreatitis/abdominal bloating/cra **STABP_40**
○ Muscle pain or weakness (myopathy/myositis/musc **STMPW_40**
cramps/spasms)
○ Burning/tingling in extremities **STBTE_40**
(neuropathy/neuritis/numbness)
○ Diarrhea **STDIA_40**
○ Kidney stones **STKID_40**
○ Renal failure **STREN_40**
○ Rash **STRAS_40**
○ High blood sugar/Diabetes **STDM_40**
○ High cholesterol/High triglycerides **STCHO_40**
○ Painful urination **STURN_40**
○ High blood pressure **STHBP_40**
○ Abnormal changes in body fat **STFAT_40**
○ Vivid nightmares or dreams **STNVD_40**
○ Liver toxicity (abnormal liver function test) **STLTX_40**
○ Insomnia or problems sleeping **STIPS_40**
○ Increased viral load **SINVL_40**
○ Decreased viral load **SDCVL_40**
○ Hospitalized **STHOS_40**
○ Personal decision **STPER_40**
○ Prescription changes by physician **STDOC_40**
○ Too expensive **STEXP_40**
○ Too much bother, inconvenient (ran out/vacation/un **STINC_40**
to fill prescription)
○ Changed to another drug in order to decrease the **STCGD_40**
number of pills or dosing frequency
○ Other, specify:

1) _____ **STOT1_40** _____
2) _____ **STOT2_40** _____
3) _____ **STOT3_40**

14. **On average, how often did you take your medication as prescribed?**
○ 100% of the time **MDPRE_40**
○ 95–99% of the time
○ 75–94% of the time
○ <75% of the time