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.

41 FORM 1—ANTI-VIRAL DRUGS

ID Number MACSID

Visit No. 410 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 (Reyataz, BMS-232632)
- ○ Combivir (AZT & 3-TC)
- ○ d4T (Zerit, Stavudine)
- ○ ddC (Dideoxycytidine, HIVID, Zalcitabine)
- ○ ddI (Dideoxyinosine, Didanosine, Videx)
- ○ Delavirdine (Rescriptor)
- ○ Efavirenz (Sustiva)
- ○ Emtriva (Emtricitabine)
- ○ Lexiva
- ○ 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: 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 / 94 95 96 97 98 99 00 01 02 03 04 05) 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 / 94 95 96 97 98 99 00 01 02 03 04 05) AVRM_## AVRY_##

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

○ pill ○ injection DORIN_##

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]

PREST_##

NUMBER OF TIMES (0 10 20 30 / 0 1 2 3 4 5 6 7 8 9) PRES1_## 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_##

IF BY PILL, SKIP TO Q8.

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

INJDU_##

NUMBER OF TIMES (0 10 20 30 / 0 1 2 3 4 5 6 7 8 9) TINJD_## 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_##**

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

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 **SEBTE_##**
     (neuropathy/neuritis/numbness)
   ○ 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 bloatin **STABP_##**
   ○ Muscle pain or weakness (myopathy/myositis/ **STMPW_##**
     cramps/spasms)
   ○ Burning/tingling in extremities **STBTE_##**
     (neuropathy/neuritis/numbness)
   ○ 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