

43 FORM 1—ANTIRETROVIRAL DRUGS

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

DATE

<input type="radio"/> Jan	DAY	YEAR
<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

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

- abacavir (Ziagen) (218)
- amprenavir (Agenerase) (219)
- atazanavir (Reyataz) (243)
- Combivir (zidovudine & lamivudine) (227)
- delavirdine (Rescriptor) (194)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- enfuvirtide (Fuzeon, T-20, pentafuside) (233)
- Epzicom (abacavir, lamivudine) (254)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- lamivudine (EpiVir, 3TC) (204)
- lopinavir (Kaletra) (217)
- nelfinavir (Viracept) (216)
- nevirapine (Viramune) (191)
- ritonavir (Norvir) (211)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- tipranavir (238)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Truvada (emtricitabine + tenofovir) (253)
- zidovudine (Retrovir, AZT) (092)

Other →

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

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) study?

- NO DON'T KNOW
 YES

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

- NO (GO TO E.) YES STOP, IF BLINDED. GO TO Q4, IF UNBLINDED.

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

IF BLINDED, STOP. GO TO NEXT DRUG.
IF UNBLINDED, GO TO Q2.

2. Are you currently taking this drug [not as part of a research study]?

- NO (GO TO Q3) YES (GO TO Q4)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A STUDY, YOU MUST COMPLETE THIS FORM FOR RESEARCH USE AND COMPLETE ANOTHER FORM FOR NON-RESEARCH DRUG USE.

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

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

- by mouth (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 PER

Day or Week or Month

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

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 MOUTH, SKIP TO Q8.

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

NUMBER OF TIMES PER

Day or Week or Month

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

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
	94	95	96	97	98	99	00	01	02	03	04	05

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

1) _____
2) _____
3) _____

- None of the above

12. Did you stop taking this drug, for 2 days or longer, 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)
 - Diarrhea
 - Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
 - Burning/tingling in extremities (neuropathy/neuritis/numbness)
 - Kidney stones
 - Kidney 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
 - Fatigue
-
- 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
 - Study ended
 - 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