47 FORM 1—ANTIRETROVIRAL DRUGS

ID Number | Visit No. | DATE (DAY / YEAR)

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**)
- ○ d4T (Zerit, Stavudine) (**159**)
- ○ 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

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
98 99 00 01 02 03 04 05 06 07 08 09

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
98 99 00 01 02 03 04 05 06 07 08 09

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

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.

CC#4

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
	98	99	00	01	02	03	04	05	06	07	08	09

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. 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 Q13) ○ YES

12. 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) _____

13. 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