

49 FORM 1—ANTIRETROVIRAL DRUGS

ID Number	Visit No.	DATE		
0 0 0 0	0 0	<input type="radio"/> Jan	DAY	YEAR
1 1 1 1	1 1	<input type="radio"/> Feb		
2 2 2 2	2 2	<input type="radio"/> Mar	0 0	00
3 3 3 3	3 3	<input type="radio"/> Apr	10 1	01
4 4 4 4	4 4 4	<input type="radio"/> May	20 2	02
5 5 5 5	5 5 5	<input type="radio"/> June	30 3	03
6 6 6 6	6 6	<input type="radio"/> July	4	04
7 7 7 7	7 7	<input type="radio"/> Aug	5	05
8 8 8 8	8 8	<input type="radio"/> Sept	6	06
9 9 9 9	9 9	<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).

- | | |
|---|---|
| <input type="radio"/> abacavir (Ziagen) (218) | <input type="radio"/> lamivudine (Epivir, 3TC) (204) |
| <input type="radio"/> atazanavir (Reyataz) (243) | <input type="radio"/> lopinavir (Kaletra) (217) |
| <input type="radio"/> Atripla (efavirenz + emtricitabine + tenofovir) (262) | <input type="radio"/> nelfinavir (Viracept) (216) |
| <input type="radio"/> Combivir (zidovudine & lamivudine) (227) | <input type="radio"/> nevirapine (Viramune) (191) |
| <input type="radio"/> d4T (Zerit, Stavudine) (159) | <input type="radio"/> ritonavir (Norvir) (211) |
| <input type="radio"/> delavirdine (Rescriptor) (194) | <input type="radio"/> saquinavir (Invirase, Fortovase) (210) |
| <input type="radio"/> didanosine (Videx) (147) | <input type="radio"/> tenofovir (Viread) (234) |
| <input type="radio"/> efavirenz (Sustiva) (220) | <input type="radio"/> tipranavir (238) |
| <input type="radio"/> emtricitabine (Emtriva, FTC) (239) | <input type="radio"/> Trizivir (abacavir + lamivudine + zidovudine) (240) |
| <input type="radio"/> enfuvirtide (Fuzeon, T-20, pentafuside) (233) | <input type="radio"/> Truvada (emtricitabine + tenofovir) (253) |
| <input type="radio"/> Epzicom (abacavir + lamivudine) (254) | <input type="radio"/> zidovudine (Retrovir, AZT) (092) |
| <input type="radio"/> fosamprenavir (Lexiva) (249) | |
| <input type="radio"/> indinavir (Crixivan) (212) | <input type="radio"/> Other → |

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

Name of Drug:

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 or liquid)
 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 or doses 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
	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