FORM 1—ANTIRETROVIRAL DRUGS

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

ID Number | Visit No. | DATE (Day / Year)

- ○ abacavir (Ziagen) (**218**)
- ○ atazanavir (Reyataz) (**243**)
- ○ Atripla (efavirenz + emtricitabine + tenofovir) (**262**)
- ○ Combivir (zidovudine & lamivudine) (**227**)
- ○ d4T (Zerit, Stavudine) (**159**)
- ○ darunavir (Prezista) (**256**)
- ○ didanosine (Videx) (**147**)
- ○ efavirenz (Sustiva) (**220**)
- ○ emtricitabine (Emtriva, FTC) (**239**)
- ○ Epzicom (abacavir + lamivudine) (**254**)
- ○ Etravirine (Intelence, TMC-125) (**255**)
- ○ fosamprenavir (Lexiva) (**249**)
- ○ indinavir (Crixivan) (**212**)
- ○ lamivudine (Epivir, 3TC) (**204**)
- ○ lopinavir/ritonavir (Kaletra, LPV) (**217**)
- ○ nelfinavir (Viracept) (**216**)
- ○ nevirapine (Viramune) (**191**)
- ○ Raltegravir (Isentress) (**264**)
- ○ ritonavir (Norvir) (**211**)
- ○ saquinavir (Invirase, Fortovase) (**210**)
- ○ tenofovir (Viread) (**234**)
- ○ 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 / 01 02 03 04 05 06 07 08 09 10 11 12)

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 / 01 02 03 04 05 06 07 08 09 10 11 12)

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)

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
	01	02	03	04	05	06	07	08	09	10	11	12

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