FORM 1—ANTIRETROVIRAL DRUGS

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 15.8(S).

- 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 (Intelicence, 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) (243)
- saquinavir (Invirase, Fortovase) (210)
- tenofovir (Viread) (234)
- Trizivir (abacavir + lamivudine + zidovudine) (240)
- Atripla (efavirenz + emtricitabine + tenofovir) (253)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (220)
- emtricitabine (Emtriva, FTC) (239)
- Epzicom (abacavir + lamivudine) (254)
- Etravirine (Intelicence, TMC-125) (255)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)

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?

3. [Since your last visit] In what month and year did you most recently take this drug?

   - F M A M J J A S O (GO TO D.)
   - D

   - DON’T KNOW

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
   - Week
   - Month

6. According to your doctor, how many pills or doses should you take each time?

   - NUMBER OF TIMES PER
   - Day
   - Week
   - Month

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

   - NUMBER OF TIMES PER
   - Day
   - Week
   - Month

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 ☐ 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