21 FORM 1 - ANTI-VIRAL DRUGS

COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 18.A(2).

☐ Acyclovir (ACV, Zovirax)
☐ AL-721
☐ Alpha Interferon
☐ Ampligen
☐ AZT (Azidothymidine, Compound S, Retrovir, Zidovudine, ZDV)
☐ AZT/ddC
☐ AZT/ddI
☐ AZT/ddI/ddC
☐ Beta Interferon
☐ d4T
☐ ddC (dideoxycytidine, Hivid, Zalcitabine)
☐ ddI (dideoxyinosine, Didanosine, Videx)
☐ ddI/ddC
☐ Dextran-Sulfate
☐ Foscarnet
☐ (Phosphonoformate, PFA)
☐ Peptide T
☐ Recombinant CD4
☐ Ribavirin
☐ 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)?

☐ NO  (GO TO F)
☐ YES
☐ DON'T KNOW  (GO TO F)

D. If YES, do you know the ACTG number?

☐ NO  (GO TO F)
☐ YES

E. What is the number of that study?

☐ 0 0 0 0
☐ 0 0 0 0
☐ 0 0 0 0

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

☐ NO
☐ YES

(STOP, GO TO NEXT DRUG)

2. Since your last visit in (MONTH), how long have you used this (DRUG)?

☐ One week or less
☐ More than 1 week but less than 1 month
☐ 1 - 2 months
☐ 3 - 4 months
☐ 5 - 6 months
☐ More than 6 months

3. Did you alternate your use of this drug with another anti-viral drug?

☐ NO  (GO TO Q5)
☐ YES

4. If YES, how often did you alternate these drugs?

☐ More often than weekly
☐ Weekly
☐ Every two weeks
☐ Monthly
☐ Less often than monthly
☐ Other alternating schedule

(GO TO Q8)

5. Did you stop altogether or decrease your daily dose of (DRUG) since your last visit?

☐ NO  (GO TO Q8)
☐ YES

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6. Why did you stop taking or decrease this drug?

(MARK ALL THAT APPLY)

○ Low white blood cells (low neutrophils)
○ Anemia (low red blood cells/low hemoglobin)
○ Bleeding
○ Dizziness/Headaches
○ Nausea/Vomiting
○ Abdominal pain (pancreatitis/abdominal bloating/cramps)
○ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)
○ Burning/tingling in extremities (neuropathy/neuritis/numbness)
○ Hospitalized
○ Personal decision
○ Prescription changes by physician
○ Too expensive
○ Too much bother, inconvenient (ran out/vacation/unable to fill prescription)
○ Other, specify:

1) 
2) 
3) 

7. Did you restart or increase your use of this drug?

○ NO
○ YES

8. What is the most recent total daily dose that you took? For example, 200 mg 3 times per day = 600 mg.

<table>
<thead>
<tr>
<th>TOTAL DAILY DOSE</th>
<th>UNITS CODE</th>
<th>(RECORD PARTICIPANT'S COMPLETE RESPONSE)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>○ Don't Know</td>
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9. Are you currently taking this drug?

○ NO
○ YES