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 (Azidodehydrocytidine, Compound S, Retrovir, Zidovudine, ZDV)
- AZT/ddC
- AZT/ddI
- AZT/ddI/ddC
- Beta Interferon
- d4T (Stavudine)
- ddC (dideoxycytidine, HIVID, Zalcitabine)
- ddI (dideoxynosine, Didanosine, Videx)
- ddI/ddC
- Dextran-Sulfate
- Foscarnet (Phosphonoformate, PFA)
- Peptide T
- Recombinant CD4
- Ribavirin
- Other

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)?
   - 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?
   
   
   
   
   
   
   
   
   
   
   

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

5. Did you stop altogether or decrease your daily dose of (DRUG) since your last visit?
   - NO (GO TO Q8)
   - YES

Please continue on the other side.
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.

   TOTAL DAILY DOSE | UNITS CODE | (RECORD PARTICIPANT’S COMPLETE RESPONSE)

   Don’t Know

9. Are you currently taking this drug?

- NO
- YES