**FORM 1—ANTI-VIRAL DRUGS**

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

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Visit No</th>
<th>DATE</th>
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- 3-TC (Epivir, Lamivudine)
- Abacavir (Ziagen)
- Adefovir (Preveon)
- Amprenavir
- AZT (Retrovir, Zidovudine)
- Combivir (AZT & 3-TC)
- d4T (Zerit, Stavudine)
- ddC (didacoxycytidine, Hivid, Zalcitabine)
- ddI (dideoxynosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Other

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)
- DONT KNOW (GO TO F)
- YES

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

- NO (GO TO F)
- YES

E. What is the number of that study?

- 0 100 200 300 400 500 600 700 800 900

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

- NO
- YES

**IF YES: STOP IF PARTICIPANT WAS BLINDED TO THE TREATMENT; IF UNBLINDED, SKIP TO Q4.**

G. [Since your last visit] In what month and year did you most recently take this drug as part of the research study?

- Jan
- Feb
- Mar
- Apr
- May
- June
- July
- Aug
- Sept
- Oct
- Nov
- Dec

**Please continue on the other side.**
6. 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

7. Have you experienced any of the following side effects from 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)
- Diarrhea
- Kidney stones
- Rash
- High blood sugar/Diabetes
- High cholesterol/High triglycerides
- Painful urination
- High blood pressure
- Fat maldistribution
- Other, specify:
  1) 
  2) 
  3) 

- None of the above

8. Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]

- NO (GO TO Q10)
- YES

9. Why did you stop taking 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)
- Diarrhea
- Kidney stones
- Rash
- High blood sugar/Diabetes
- High cholesterol/High triglycerides
- Painful urination
- High blood pressure
- Fat maldistribution
- 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)
- Other, specify:
  1) 
  2) 
  3) 

10. 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