FORM 1—ANTI-VIRAL DRUGS

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

○ 3-TC (Epivir, Lamivudine) ○ Delavirdine (Rescriptor)
○ Abacavir (Ziagen) ○ Efavirenz (Sustiva)
○ Adefovir (Preveon) ○ Indinavir (Crixivan)
○ Amprenavir ○ Nelfinavir (Viracept)
○ AZT (Retrovir, Zidovudine) ○ Nevirapine (Viramune)
○ Combivir (AZT & 3-TC) ○ Ritonavir (Norvir)
○ d4T (Zerit, Stavudine) ○ Saquinavir (Invirase, Fortovase)
○ ddC (didoxycytidine, HVID, Zalcitabine) ○ Other
○ ddI (didoxycytidine, Didanosine, Videx)

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) ○ DON'T 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?

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

STOP IF PARTICIPANT WAS BLINDED TO THE TREATMENT AND GO TO NEXT DRUG.

2. Are you currently taking this drug [not as part of a research study]?
○ NO ○ YES (GO TO Q4)

IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

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

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

4. Did you start taking this drug since your last visit?
○ NO (GO TO Q6) ○ YES

5. [Since your last visit] In what month and year did you start taking this drug?

○ 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

   Other, specify:
   1) 
   2) 
   3) 

   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