FORM 1—ANTI-VIRAL DRUGS

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

- 3-TC (Epivir, Lamivudine)
- Abacavir (Zidovudine)
- Adefovir (Preveon)
- Amprenavir (Agenerase)
- AZT (Retrovir, Zidovudine)
- Combivir (AZT & 3-TC)
- d4T (Zerit, Stavudine)
- ddC (diddiecyctydin, HIVID, Zalcitabine)
- ddI (diddeoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- 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)  
   - 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?
   - [Blank]

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
- Nightmares/Vivid dreams
- Liver toxicity (abnormal liver function test)
- 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
- Nightmares/Vivid dreams
- Liver toxicity (abnormal liver function test)
- 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
- 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