35 FORM 1—ANTI-VIRAL DRUGS

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

- 3-TC (Epivir, Lamivudine)
- Abacavir (Ziagen)
- Amprenavir (Agenerase)
- AZT (Retrovir, Zidovudine)
- Combivir (AZT & 3-TC)
- d4T (Zerit, Stavudine)
- ddC (dideoxycytidine, Hivid, Zalcitabine)
- ddI (dideoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Efavirenz (Sustiva)
- Indinavir (Crixivan)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Trizivir (abacavir + zidovudine + lamivudine)
- 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
   - DON'T KNOW
   - YES

   D. 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.

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

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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?

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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?

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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