**FORM 1—ANTI-VIRAL DRUGS**

**COMPLETE THE FOLLOWING FOR EACH DRUG LISTED IN QUESTION 15.B(3).**

<table>
<thead>
<tr>
<th>ID Number</th>
<th>Visit No.</th>
<th>DATE</th>
<th>Name of Drug</th>
<th>Drug Code</th>
</tr>
</thead>
<tbody>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>3-TC (Epivir, Lamivudine)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Indinavir (Crixivan)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Lopinavir (Lopinavir)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Nelfinavir (Nelfinavir)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Nevirapine (Nevirapine)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Ritonavir (Ritonavir)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Saquinavir (Saquinavir)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Tenofur (Tenofur)</td>
<td>T-20</td>
</tr>
<tr>
<td>1-1</td>
<td>1-1</td>
<td>1/1</td>
<td>Trizivir (Trizivir)</td>
<td>T-20</td>
</tr>
</tbody>
</table>

2. Are you currently taking this drug [not as part of a research study]?

   - ○ NO
   - ■ YES

   **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 as part of the research study?

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

4. According to your doctor, how many times a day should you take (DRUG)? [IF NOT CURRENTLY TAKING DRUG, USE MOST RECENT TIME]

   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5
   - ○ 6
   - ○ 7
   - ○ 8
   - ○ 9

5. According to your doctor, how many pills should you take each time?

   - ○ 1
   - ○ 2
   - ○ 3
   - ○ 4
   - ○ 5

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

Mark Refex® forms by NCS Pearson EM-203768-13:654321  Printed in U.S.A.
6. Did you start taking this drug since your last visit?  
☐ NO  (GO TO Q8)  ☐ YES

7. [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  

8. Since your last visit in (MONTH), how long have you used (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

9. Have you experienced any of the following side effects while taking (DRUG)? (MARK ALL THAT APPLY)  
☐ Low white blood cells (low neutrophils)  ☐ Anemia (low red blood cells/low hemoglobin)  ☐ Blood in urine  ☐ 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  ☐ Renal failure  ☐ Rash  ☐ High blood sugar/Diabetes  ☐ High cholesterol/High triglycerides  ☐ Painful urination  ☐ High blood pressure  ☐ Abnormal changes in body fat  ☐ Vivid nightmares or dreams  ☐ Liver toxicity (abnormal liver function test)  ☐ Insomnia or problems sleeping  ☐ 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)

☐ None of the above

10. Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]  
☐ NO  (GO TO Q12)  ☐ YES

11. Why did you stop taking this drug? (MARK ALL THAT APPLY)  
☐ Low white blood cells (low neutrophils)  ☐ Anemia (low red blood cells/low hemoglobin)  ☐ Blood in urine  ☐ 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  ☐ Renal failure  ☐ Rash  ☐ High blood sugar/Diabetes  ☐ High cholesterol/High triglycerides  ☐ Painful urination  ☐ High blood pressure  ☐ Abnormal changes in body fat  ☐ Vivid nightmares or dreams  ☐ Liver toxicity (abnormal liver function test)  ☐ Insomnia or problems sleeping  ☐ 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)

12. 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