FORM 1—ANTI-VIRAL DRUGS

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

- 3-TC (Epivir, Lamivudine)
- Abacavir (Ziagen)
- Amprenavir (Agenerase)
- AZT (Retrovir, Zidovudine)
- Atazanavir (BMS-232632)
- Combivir (AZT & 3-TC)
- ddC (Dideoxycytidine, HIVID, Zalcitabine)
- ddI (Dideoxyinosine, Didanosine, Videx)
- Delavirdine (Rescriptor)
- Elavirenz (Sustiva)
- Indinavir (Crixivan)
- Lopinavir/ritonavir (Kaletra)
- Nelfinavir (Viracept)
- Nevirapine (Viramune)
- Ritonavir (Norvir)
- Saquinavir (Invirase, Fortovase)
- Tenofovir (Viread)
- Trizivir (Abacavir + Zidovudine + Lamivudine)
- T-20
- 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?
   - [Calendar Year]

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?
   - J F M A M J J A S O N D
   - 1992-2003

4. Do you take this drug orally by pill or receive it by injection?
   - pill
   - injection

   IF BY INJECTION, SKIP TO Q7.

5. 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

6. According to your doctor, how many pills should you take each time?
   - 1 2 3 4 5 6 7 8 9 10

   IF BY PILL, SKIP TO Q8.

7. How many times per day, week, or month do you inject this drug?

   NUMBER OF TIMES
   - 0 10 20 30
   - 0 1 2 3 4 5 6 7 8 9

   PER
   - Day
   - or
   - Week
   - or
   - Month

Please continue on the other side.
8. Did you **start** taking this drug since your last visit?
   - [ ] NO   **(GO TO Q10)**
   - [ ] YES

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

   - [J] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [F] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [M] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [A] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [S] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [O] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [N] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31
   - [D] 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

10. 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 (includes 2 months and longer, but less than 3 months)
   - [ ] 3–4 months (includes 4 months and longer, but less than 5 months)
   - [ ] 5–6 months
   - [ ] More than 6 months

11. 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

12. Did you stop taking this drug at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]
   - [ ] NO   **(GO TO Q14)**
   - [ ] YES

13. 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) ___________________________

14. 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