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

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

- [ ] January
- [ ] February
- [ ] March
- [ ] April
- [ ] May
- [ ] June
- [ ] July
- [ ] August
- [ ] September
- [ ] October
- [ ] November
- [ ] December

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
- 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  [ ] 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