Form 1—Anti-Viral Drugs

Complete the following for each drug listed in question 15.B(3).

If you said you were taking (DRUG) since your last visit:

1. Did you take this drug as part of a research study?
   - NO
   - YES
   - DON'T KNOW

2. Are you currently taking this drug [not as part of a research study]?
   - NO
   - YES

3. Since your last visit, in what month and year did you most recently take this drug?
   - DAY
   - WEEK
   - MONTH

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

5. According to your doctor, how many times per day, week, or month should you take (DRUG)? [If not currently taking drug, use most recent time]
   - NUMBER OF TIMES
   - PER
   - Day
   - Week
   - Month

6. According to your doctor, how many pills should you take each time?
   - NUMBER OF TIMES
   - PER
   - Day
   - Week
   - Month

7. How many times per day, week, or month do you inject this drug?
   - NUMBER OF TIMES
   - PER
   - Day
   - Week
   - Month

Solution:

A. Did you take this drug as part of a research study?
   - NO  (GO TO Q2)
   - YES  RESF1_##

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  PLCF1_##

C. Was this part of the AIDS Clinical Trial Group (ACTG)?
   - NO
   - DON'T KNOW
   - YES  ACTF1_##

D. Are you currently taking this drug as part of the research study?
   - NO
   - YES  RNWF1_##

   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?
   - J  F  M  A  M  J  J  A  S  O  N
   - 04 05 06 07 08 09 10 11 12 01 02 03

   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) AVNW_##

   IF YES, BUT DRUG WAS PREVIOUSLY TAKEN AS PART OF A TRIAL, REMEMBER TO COMPLETE A SECOND DRUG FORM.

3. Name of Drug:
   - 3-TC (Epivir, Lamivudine)
   - Abacavir (Ziagen)
   - Amprenavir (Agenerase)
   - AZT (Retrovir, Zidovudine)
   - Atazanavir (Reyataz, BMS-232632)
   - Combivir (AZT & 3-TC)
   - ddT (Zerit, Stavudine)
   - ddC (Dideoxycytidine, HIVID, Zalcitabine)
   - ddI (Dideoxyinosine, Didanosine, Videx)
   - Delavirdine (Rescriptor)
   - EFavirenz (Sustiva)
   - Emtriva (Emtricitabine)
   - Fuzeon (Pentafuside, Efuvirtude, T-20)
   - Indinavir (Crixivan)
   - Lopinavir/ritonavir (Kaletra)
   - Nelfinavir (Viracept)
   - Nevirapine (Viramune)
   - Ritonavir (Norvir)
   - Saquinavir (Invirase, Fortovase)
   - Trizivir (Abacavir + Zidovudine + Lamivudine)
   - Other

4. Drug Code
   - 0 1 2 3 4 5 6 7 8 9

5. ID Number
   - 1 2 3 4 5 6 7 8 9

Please continue on the other side.
8. Did you start taking this drug since your last visit?  
☐ NO  (GO TO Q10)  ☐ YES  START_##

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  
AVSM_##  AVSY_##

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  
LENAV_##

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  ☐ 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:  
SEOT1_##  SEOT2_##  SEOT3_##

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  DECAV_##

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  ☐ Dizziness/Headaches  ☐ Nausea/Vomiting  ☐ Abdominal pain (pancreatitis/abdominal bloating/cramps/spasms)  ☐ 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)  STOT1_##  
2)  STOT2_##  
3)  STOT3_##

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  
MDPRE_##