45 FORM 1—ANTIRETROVIRAL DRUGS

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

[Drug List]
- abacavir (Ziagen) (218)
- amprrenavir (Agenerase) (219)
- atazanavir (Reyataz) (243)
- Combivir (zidovudine & lamivudine) (227)
- d4T (Zerit, stavudine) (159)
- delavirdine (Rescriptor) (194)
- didanosine (Videx) (147)
- efavirenz (Sustiva) (228)
- enfuvirtide (Fuzeon, T-20, pentafuside) (233)
- Epzicom (abacavir, lamivudine) (254)
- fosamprenavir (Lexiva) (249)
- indinavir (Crixivan) (212)
- 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 [RESF1_45]

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_45]

C. Was this part of the AIDS Clinical Trial Group (ACTG) study?
   ○ NO
   ○ DON'T KNOW
   ○ YES [ACTF1_45]

D. Are you currently taking this drug as part of the research study?
   ○ NO [GO TO E.]
   ○ YES [STOP, IF BLINDED, GO TO Q4, IF UNBLINDED, RWNF1_45]

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

<table>
<thead>
<tr>
<th>Day</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>4</td>
<td>3</td>
</tr>
<tr>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>6</td>
<td>5</td>
</tr>
<tr>
<td>7</td>
<td>6</td>
</tr>
<tr>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>9</td>
<td>8</td>
</tr>
<tr>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>

3. [Since your last visit] In what month and year did you most recently take this drug?

<table>
<thead>
<tr>
<th>Day</th>
<th>Month</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td>6</td>
</tr>
<tr>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>9</td>
<td>10</td>
</tr>
</tbody>
</table>

4. Do you take this drug by mouth or receive it by injection?
   ○ by mouth (pill)
   ○ injection [DORIN_45]

   [IF BY INJECTION, SKIP TO Q7.]

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 [PRES1_45]
   ○ Month [PREST_45]

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

   NUMBER
   ○ Day
   ○ Week
   ○ Month [NPILT_45]

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

   NUMBER
   ○ Day
   ○ Week
   ○ Month [TINJ_45]

Please continue on the other side.
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. Did you stop taking this drug, for 2 days or longer, at any time since your last visit? [DOES NOT INCLUDE ALTERNATING DRUG USE]
   ○ NO [GO TO Q13]  
   ○ YES  

12. 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)  
   ○ Diarrhea  
   ○ Muscle pain or weakness (myopathy/myositis/muscle cramps/spasms)  
   ○ Burning/tingling in extremities  
   ○ Kidney stones  
   ○ Kidney 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  
   ○ Fatigue  

13. 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