# 37 ANTIVIRAL MEDICATION ADHERENCE FORM

ID Number | Visit No. | Date (Jan–Dec; DAY; YEAR 01 02)

Most people with HIV have many pills to take at different times during the day.

Many people find it hard to always remember their pills.

- Some people get busy and forget to carry their pills with them.
- Some people find it hard to take their pills according to all the instructions, such as "take with meals" or "take every 8 hours".
- Some people decide to skip, reduce or stop doses to avoid side effects.

We need to understand how people with HIV are really doing with their medication doses.

**MARKING INSTRUCTIONS**
- Use a No. 2 pencil only.
- Do not use ink, ballpoint, or felt tip pens.
- Make solid marks that fill the circle completely.
- Erase cleanly any marks you wish to change.
- Make no stray marks on this form.

RIGHT MARK ● WRONG MARKS ✓ ✗

1. This section of the questionnaire asks about anti-HIV medications you are currently taking.

**PLEASE PUT THE DRUG NAME IN THE BOX AND FILL IN THE CORRECT DRUG CODE BELOW THE DRUG NAME.**

| Name of Drug: 1 | Name of Drug: 2 | Name of Drug: 3 |
|---|---|---|
| Drug Code | Drug Code | Drug Code |

How many TIMES did you actually take this medication?

| | | | |
|---|---|---|---|
| Yesterday | | | |
| 2 days ago [DAY] | | | |
| 3 days ago [DAY] | | | |
| 4 days ago [DAY] | | | |
| Is this pattern typical of your recent use of [DRUG]? | No Yes | No Yes | No Yes |
| Was there any time in the last 4 days that you took fewer PILLS per dose (time) than were prescribed? | No Yes | No Yes | No Yes |

**PLEASE CONTINUE ON THE NEXT PAGE IF PARTICIPANT IS CURRENTLY TAKING MORE THAN THREE MEDICATIONS. OTHERWISE, SKIP TO Q.2.**



SERIAL #

PLEASE DO NOT WRITE IN THIS AREA

| Name of Drug: 4 | Name of Drug: 5 | Name of Drug: 6 |
|---|---|---|
| Drug Code | Drug Code | Drug Code |
| 0 100 200 300 400 500 600 700 800 900 | 0 100 200 300 400 500 600 700 800 900 | 0 100 200 300 400 500 600 700 800 900 |
| 0 10 20 30 40 50 60 70 80 90 | 0 10 20 30 40 50 60 70 80 90 | 0 10 20 30 40 50 60 70 80 90 |
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |

**How many TIMES did you actually take this medication?**

| | | | |
|---|---|---|---|
| Yesterday | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| 2 days ago [DAY] | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| 3 days ago [DAY] | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| 4 days ago [DAY] | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| Is this pattern typical of your recent use of [DRUG]? | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |
| Was there any time in the last 4 days that you took fewer PILLS per dose (time) than were prescribed? | ○ No ○ Yes | ○ No ○ Yes | ○ No ○ Yes |

**PLEASE CONTINUE ON THE NEXT PAGE IF PARTICIPANT IS CURRENTLY TAKING MORE THAN SIX MEDICATIONS. OTHERWISE, SKIP TO Q.2.**

| Name of Drug: 7 | Name of Drug: 8 | Name of Drug: 9 |
|---|---|---|
| Drug Code | Drug Code | Drug Code |
| 0 100 200 300 400 500 600 700 800 900 | 0 100 200 300 400 500 600 700 800 900 | 0 100 200 300 400 500 600 700 800 900 |
| 0 10 20 30 40 50 60 70 80 90 | 0 10 20 30 40 50 60 70 80 90 | 0 10 20 30 40 50 60 70 80 90 |
| 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |

**How many TIMES did you actually take this medication?**

| | | | |
|---|---|---|---|
| **Yesterday** | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| **2 days ago [DAY]** | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| **3 days ago [DAY]** | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| **4 days ago [DAY]** | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 | 0 1 2 3 4 5 6 7 8 9 |
| **Is this pattern typical of your recent use of [DRUG]?** | ◯ No ◯ Yes | ◯ No ◯ Yes | ◯ No ◯ Yes |
| **Was there any time in the last 4 days that you took fewer PILLS per dose (time) than were prescribed?** | ◯ No ◯ Yes | ◯ No ◯ Yes | ◯ No ◯ Yes |

**2. When was the last time you skipped any of your medications?**

- ◯ Never skip medications → **IF NEVER, SKIP TO Q.4.**
- ◯ Within the past week
- ◯ 1–2 weeks ago
- ◯ 3–4 weeks ago
- ◯ 1–3 months ago
- ◯ More than 3 months ago

3. People miss taking their medications for various reasons. Here is a list of possible reasons.

How often have you missed taking your current medications because you:

| | Never | Rarely | Sometimes | Often |
|---|---|---|---|---|
| a. Were away from home? | ○ | ○ | ○ | ○ |
| b. Were busy with other things? | ○ | ○ | ○ | ○ |
| c. Simply forgot? | ○ | ○ | ○ | ○ |
| d. Had too many pills to take? | ○ | ○ | ○ | ○ |
| e. Wanted to avoid side effects? | ○ | ○ | ○ | ○ |
| f. Did not want others to notice you taking medication? | ○ | ○ | ○ | ○ |
| g. Had a change in daily routine? (e.g., vacation, holiday, non-work day) | ○ | ○ | ○ | ○ |
| h. Felt like the drug was toxic or harmful? | ○ | ○ | ○ | ○ |
| i. Fell asleep/slept through dose time? | ○ | ○ | ○ | ○ |
| j. Felt sick or ill? | ○ | ○ | ○ | ○ |
| k. Felt depressed or overwhelmed? | ○ | ○ | ○ | ○ |
| l. Had problems taking the pills? | ○ | ○ | ○ | ○ |
| m. Ran out of pills? | ○ | ○ | ○ | ○ |
| n. Don't want to take pills? | ○ | ○ | ○ | ○ |
| o. Have special instructions that conflict? | ○ | ○ | ○ | ○ |
| p. Other? | ○ | ○ | ○ | ○ |

→ Specify:

4. Most anti-HIV medications need to be taken on a schedule, such as "2 times a day" or "every 8 hours." How closely did you follow your specific schedule over the last four days?

- ○ Never
- ○ Some of the time
- ○ About half of the time
- ○ Most of the time
- ○ All of the time

5. Do any of your anti-HIV medications have special instructions such as "take with food" or "take on an empty stomach" or "take with plenty of fluids"?

- ○ No → SKIP TO Q6
- ○ Yes

IF YES, how often did you follow those special instructions over the last four days?

- ○ Never
- ○ Some of the time
- ○ About half of the time
- ○ Most of the time
- ○ All of the time

Do any of these special instructions conflict?

- ○ No
- ○ Yes

6. How do you remember to take your medications?

| | No | Yes |
|---|---|---|
| a. Calendar/diary | ○ | ○ |
| b. Pill box | ○ | ○ |
| c. Alarm | ○ | ○ |
| d. Friend/family member | ○ | ○ |
| e. Memory only | ○ | ○ |
| f. Other | ○ | ○ |

→ Specify:

SERIAL #

PLEASE DO NOT WRITE IN THIS AREA