

38 ANTIVIRAL MEDICATION ADHERENCE FORM

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.

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MARKING INSTRUCTIONS	RIGHT MARK	WRONG MARKS
<ul style="list-style-type: none"> • Use a No. 2 pencil only. • Do not use ink, ballpoint, or felt tip pens. 	<ul style="list-style-type: none"> • Make solid marks that fill the circle completely. 	<ul style="list-style-type: none"> • Erase cleanly any marks you wish to change. • Make no stray marks on this form.

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.

<p>Name of Drug:</p> <input type="text" value="1"/>	<p>Name of Drug:</p> <input type="text" value="2"/>	<p>Name of Drug:</p> <input type="text" value="3"/>																																																																																																			
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How many TIMES did you actually take this medication?

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Is this pattern typical of your recent use of [DRUG]?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Was there any time in the last 4 days that you took fewer PILLS per dose (time) than were prescribed?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes

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

Name of Drug:
4

Drug Code

<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90
<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9

Name of Drug:
5

Drug Code

<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900
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<input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9

Name of Drug:
6

Drug Code

<input type="checkbox"/>	0	100	200	300	400	500	600	700	800	900
<input type="checkbox"/>	0	10	20	30	40	50	60	70	80	90
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How many TIMES did you actually take this medication?

Yesterday	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9	<input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9
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Is this pattern typical of your recent use of [DRUG]?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes
Was there any time in the last 4 days that you took fewer PILLS per dose (time) than were prescribed?	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> Yes	<input type="radio"/> No <input type="radio"/> 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

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Drug Code

0	100	200	300	400	500	600	700	800	900
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0	1	2	3	4	5	6	7	8	9

Name of Drug:
8

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Drug Code

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

Name of Drug:
9

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Drug Code

0	100	200	300	400	500	600	700	800	900
0	10	20	30	40	50	60	70	80	90
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?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
b. Were busy with other things?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
c. Simply forgot?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
d. Had too many pills to take?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
e. Wanted to avoid side effects?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
f. Did not want others to notice you taking medication?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
g. Had a change in daily routine? (e.g., vacation, holiday, non-work day)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
h. Felt like the drug was toxic or harmful?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
i. Fell asleep/slept through dose time?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
j. Felt sick or ill?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
k. Felt depressed or overwhelmed?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
l. Had problems taking the pills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
m. Ran out of pills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
n. Don't want to take pills?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
o. Have special instructions that conflict?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
p. Other?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

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	<input type="radio"/>	<input type="radio"/>
b. Pill box	<input type="radio"/>	<input type="radio"/>
c. Alarm	<input type="radio"/>	<input type="radio"/>
d. Friend/family member	<input type="radio"/>	<input type="radio"/>
e. Memory only	<input type="radio"/>	<input type="radio"/>
f. Other	<input type="radio"/>	<input type="radio"/>

Specify:



PLEASE DO NOT WRITE IN THIS AREA

SERIAL #