

39 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.

ID Number	Visit No.	Date		
<input type="text"/>	<input type="text"/>	<input type="radio"/> Jan	DAY	YEAR
<input type="text"/>	<input type="text"/>	<input type="radio"/> Feb	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Mar	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Apr	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> May	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> June	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> July	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Aug	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Sept	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Oct	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Nov	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="radio"/> Dec	<input type="text"/>	<input type="text"/>

MARKING INSTRUCTIONS <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. • Erase cleanly any marks you wish to change. • Make no stray marks on this form. 	RIGHT MARK 	WRONG MARKS    
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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: <input type="text"/>	Name of Drug: <input type="text"/>	Name of Drug: <input type="text"/>
Drug Code <input type="text"/> 0 <input type="text"/> 100 <input type="text"/> 200 <input type="text"/> 300 <input type="text"/> 400 <input type="text"/> 500 <input type="text"/> 600 <input type="text"/> 700 <input type="text"/> 800 <input type="text"/> 900 <input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90 <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9	Drug Code <input type="text"/> 0 <input type="text"/> 100 <input type="text"/> 200 <input type="text"/> 300 <input type="text"/> 400 <input type="text"/> 500 <input type="text"/> 600 <input type="text"/> 700 <input type="text"/> 800 <input type="text"/> 900 <input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90 <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9	Drug Code <input type="text"/> 0 <input type="text"/> 100 <input type="text"/> 200 <input type="text"/> 300 <input type="text"/> 400 <input type="text"/> 500 <input type="text"/> 600 <input type="text"/> 700 <input type="text"/> 800 <input type="text"/> 900 <input type="text"/> 0 <input type="text"/> 10 <input type="text"/> 20 <input type="text"/> 30 <input type="text"/> 40 <input type="text"/> 50 <input type="text"/> 60 <input type="text"/> 70 <input type="text"/> 80 <input type="text"/> 90 <input type="text"/> 0 <input type="text"/> 1 <input type="text"/> 2 <input type="text"/> 3 <input type="text"/> 4 <input type="text"/> 5 <input type="text"/> 6 <input type="text"/> 7 <input type="text"/> 8 <input type="text"/> 9

How many TIMES did you actually take this medication?

	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
Yesterday	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
2 days ago [DAY]	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
3 days ago [DAY]	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
4 days ago [DAY]	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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.

 PLEASE DO NOT WRITE IN THIS AREA	SERIAL #
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Name of Drug:

4

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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

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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:

6

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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

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
2 days ago [DAY]	<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
3 days ago [DAY]	<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
4 days ago [DAY]	<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

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

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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:
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 #