Medication Adherence Assessment I

Please answer the following questions to assist your physician in prescribing the most appropriate medications to treat your HIV infection. **It is important that you do not miss or skip your dose of HIV medication. Skipping or missing your dose can make HIV in your body "resistant" to the medications. Skipping or missing your dose may put you at risk for getting sick.**

1. My schedule every day is:

   ☐ The same every day ☐ Different on weekends ☐ Never the same

   ☐ Different on the days that I go to work or school

2. What meals do you usually eat and the time that you eat.

   ☐ Breakfast
   Time: _____ o'clock in the morning

   ☐ Lunch:
   Time: _____ o'clock in the afternoon

   ☐Dinner:
   Time: _____ o'clock in the evening

   ☐ I eat my meals at different times during the day and not the same each day.

3. I am willing to take medications:

   ☐Once a day ☐ 2 times a day ☐ 3 to 4 times a day ☐more than 4 times a day

4. I would be willing to take:

   ☐ only 1 pill at a time ☐ 2 to 3 pills at a time ☐ 4 to 5 pills at a time

   ☐ more than 5 pills at a time

5. What are the best times for you to take your medications?
   (Check all the times that will work for you)

   ☐ When I first wake up. ☐ When I eat breakfast. ☐ When I eat lunch.

   ☐ When I get home from work or school. ☐ When I eat dinner.

   ☐ Right before I go to sleep.

Write down any other times you feel would be good for you to take medications.

_____

6. Some HIV medications need to be taken on an "empty stomach" which means that you take the medication 1 hour before or 2 hours after you eat. Do you think such a medication would be…?

☐ Easy to remember to take. ☐ Hard to remember to take at the right time.

7. What is your current housing/living situation?

☐ own house/apartment ☐ someone else's house/apartment ☐ transitional housing

☐ on the streets

8. Do you have access to a refrigerator?

☐ yes ☐ no

9. Do you or have you used illicit drugs (marijuana, cocaine, crack, heroin, etc.) or alcohol?

☐ yes, current ☐ no, not current ☐ yes, in the past ☐ no, never

If yes what drugs do/have you used and when was the last time that you used the substance?

_____ Date: _____

_____ Date: _____

_____ Date: _____

10. Are you currently on methadone?

☐ yes ☐ no

11. Check all that apply as your current social support system:

☐ family ☐ friends ☐ spouse/significant other ☐ faith based

☐ other: _____

12. Check all the concerns that you have about taking HIV medications:

☐ I'm afraid I'll forget to take my medications at the right time.

☐ I think it would be hard for me to remember to take my medications with food if required.

☐ I don't like to take a lot of pills.

☐ It's hard for me to swallow pills.

☐ I'm afraid if people see me taking my medications they will know that I have HIV/AIDS.

☐ I'm worried that my HIV medications may cause problems with other medications that I take.

☐ I'm afraid that the HIV medications will not work for me.

☐ I'm afraid the HIV medication will make me feel sick.

☐ I'm afraid that the medications will stop working if I forget to take the medications on time.

☐ Other concerns: _____

13. HIV medications may cause side effects. Which of the side effects listed below causes you concern? Check all that apply:

☐ rash ☐ diarrhea ☐ loss of appetite ☐ fatigue or feeling tired ☐ headache ☐ stomachache

☐ feeling like I have to throw up ☐ throwing up ☐ nightmares

☐ having my hands or feet feel like they're asleep, tingling, or with prickly pain.

☐ hair loss ☐ ingrown toenails or fingernails

14. How can we assist you to ensure that you will take your medication as prescribed?

_____

_____

Medication Adherence Assessment II
(Patient presently on medications)

Please answer the following questions to assist your physician in assessing your current medications and to prescribe the most appropriate medications to treat your HIV infection. **It is important that you do not miss or skip your dose of HIV medication. Skipping or missing your dose can make HIV in your body resistant to the medications. Skipping or missing your dose may put you at risk for getting sick.**

1. What medications are you presently taking?

   _____

   _____

2. I am taking medications:

   ☐ Once a day ☐ 2 times a day ☐ 3 to 4 times a day ☐ more than 4 times a day

3. I think I am able to take:

   ☐ only 1 pill at a time ☐ 2 to 3 pills at a time ☐ 4 to 5 pills at a time

   ☐ more than 5 pills at a time

4. What are the best times for you to take your medications?
   (check all the times that will work for you)

   ☐ When I first wake up. ☐ When I eat breakfast. ☐ When I eat lunch.

   ☐ When I get home from work or school. ☐ When I eat dinner. ☐ Right before I go to sleep.

   Write down any other times you feel would be good for you to take medications.

   _____

5. Which of the side effects listed below have you experienced on your current medications? Check all that apply:

   ☐ rash ☐ diarrhea ☐ loss of appetite ☐ fatigue or feeling tired

   ☐ headache ☐ stomachache ☐ feeling like I have to throw up

   ☐ throwing up ☐ nightmares

   ☐ having my hands or feet feel like they're asleep, tingling, or with prickly pain.

   ☐ hair loss ☐ ingrown toenails or fingernails

Comments:

_____

_____

_____

_____

6. What meals do you usually eat and the time that you eat.

☐ Breakfast
Time: _____ o'clock in the morning

☐ Lunch:
Time: _____ o'clock in the afternoon

☐Dinner:
Time: _____ o'clock in the evening

☐ I eat my meals at different times during the day and not the same each day.

7. Some HIV medications need to be taken on an "empty stomach" which means that you take the medication 1 hour before or 2 hours after you eat. Do you think such a medication would be…?

☐ Easy to remember to take. ☐ Hard to remember to take at the right time.

8. Check all the concerns that you have about taking HIV medications:

☐ I'm afraid I'll forget to take my medications at the right time.

☐ I think it would be hard for me to remember to take my medications with food if required.

☐ I don't like to take a lot of pills.

☐ It's hard for me to swallow pills.

☐ I'm afraid if people see me taking my medications they will know that I have HIV/AIDS.

☐ I'm worried that my HIV medications may cause problems with other medications that I take.

☐ I'm afraid that the HIV medications will not work for me.

☐ I'm afraid the HIV medication will make me feel sick.

☐ I'm afraid that the medications will stop working if I forget to take the medications on time.

☐ Other concerns:

_____

9. What is your current housing/living situation?

☐ own house/apartment ☐ someone else's house/apartment ☐ transitional housing

☐ on the streets

10. Do you have access to a refrigerator? ☐ yes ☐ no

11. Do you or have you used illicit drugs (marijuana, cocaine, crack, heroin, etc.) or alcohol?

☐ yes, current ☐ no, not current ☐ yes, in the past ☐ no, never

If yes what drugs do/have you used and when was the last time that you used the substance?

_____ Date: _____

_____ Date: _____

_____ Date: _____

12. Are you currently on methadone?

☐ yes ☐ no

13. Check the social support systems that currently apply to you:

☐ family ☐ friends ☐ spouse/significant other ☐ faith based

☐ other: _____

14. How can we assist you to ensure that you will take your medication as prescribed?

_____

_____