ACTG Adherence Baseline Questionnaire

Date: _____

Patient ID: _____

How Administered? Self ☐ 1 Interviewer ☐ 2 Both ☐ 3

The answers you give on this form will be used to plan ways to help other people who must take pills on a difficult schedule. Please do the best you can to answer all the questions. If you do not wish to answer a question, please draw a line through it. If you do not know how to answer a question, ask your study nurse to help. Thank you for helping in this important study.

INSTRUCTIONS: Please answer the following questions by placing a circle around the appropriate number response.

A. How sure are you that:

Please circle one response for each question.

		Not at All Sure	Somewhat Sure	Very Sure	Extremely Sure
1.	You will be able to take all or most of the study medication as directed?	0	1	2	3
2.	The medication will have a positive effect on your health?	0	1	2	3
3.	If you do not take this medication exactly as instructed, the HIV in your body will become resistant to HIV medications?	0	1	2	3

B. The following questions ask about your social support.

Please circle one response for each question.

		Very Dissatisfied	Somewhat Dissatisfied	Somewhat Satisfied	Very Satisfied
1.	In general, how satisfied are you with the overall support you get from your friends and family members?	0	1	2	3

		Not At All	A Little	Somewhat	A Lot	Not Applicable
2.	To what extent do your friends or family members help you remember to take your medication?	0	1	2	3	4

C. People may miss taking their medications for various reasons. Here is a list of possible reasons why you may have missed taking any medications within the **past month**.

If you have **NOT** taken **any** medications within the **past month**, please check this box and skip to Section D. ☐ 1

In the past month, how often have you missed taking your medications because you:

Please circle one response for each question.

		Never	Rarely	Sometimes	Often
1.	Were away from home?	0	1	2	3
2.	Were busy with other things?	0	1	2	3
3.	Simply forgot?	0	1	2	3
4.	Had too many pills to take?	0	1	2	3
5.	Wanted to avoid side effects?	0	1	2	3
6.	Did not want others to notice you taking medication?	0	1	2	3
7.	Had a change in daily routine?	0	1	2	3
8.	Felt like the drug was toxic/harmful?	0	1	2	3
9.	Fell asleep/slept through dose time?	0	1	2	3
10.	Felt sick or ill?	0	1	2	3
11.	Felt depressed/overwhelmed?	0	1	2	3
12.	Had problem taking pills at specified times (with meals, on empty stomach, etc.)?	0	1	2	3
13.	Ran out of pills?	0	1	2	3
14.	Felt good?	0	1	2	3

D. When was the last time you missed taking any of your medications? Check one box.

☐ 5 Within the past **week**

☐ 4 1-2 **weeks** ago

☐ 3 2-4 **weeks** ago

☐ 2 1-3 **months** ago

☐ 1 More than 3 **months** ago

☐ 0 **Never** skip medications or **not applicable**

E. In the <u>past week</u> how often did you:

Please circle one response for each question.

		Never/ Rarely	Sometimes	Often	Mostly or Always
1.	Feel like you couldn't shake off the blues even with help from your family or friends?	0	1	2	3
2.	Have trouble keeping your mind on what you were doing?	0	1	2	3
3.	Feel that everything you did was an effort?	0	1	2	3
4.	Have trouble sleeping?	0	1	2	3
5.	Feel lonely?	0	1	2	3
6.	Feel sad?	0	1	2	3
7.	Feel like you just couldn't "get going"?	0	1	2	3

F. In the <u>past month</u>, how often have you:

Please circle one response for each question.

		Never	Almost Never	Sometimes	Fairly Often	Very Often
1.	Been upset because of something that happened unexpectedly?	0	1	2	3	4
2.	Felt unable to control the important things in in your life?	0	1	2	3	4
3.	Felt nervous and “stressed”?	0	1	2	3	4
4.	Felt confident in your ability to handle your personal problems?	0	1	2	3	4
5.	Felt that things were going your way?	0	1	2	3	4
6.	Found that you could not cope with all the things that you had to do?	0	1	2	3	4
7.	Been able to control irritations in your life?	0	1	2	3	4
8.	Felt that you were on top of things?	0	1	2	3	4
9.	Been angered because of things that happened that were outside of your control?	0	1	2	3	4
10.	Felt problems were piling up so high that you could not overcome them?	0	1	2	3	4

G. People have various health habits. The following questions ask about your alcohol and drug use, past and current.

1. How often have you had a drink containing alcohol – a glass of beer, wine, a mixed drink, or any kind of alcoholic beverage – in the last 30 days? Check one.

Daily	Nearly Every Day	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month	Never
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

⇩

*If **Never**, skip ahead to question **#4**.*

2. On days when you drank any alcoholic beverages in the last 30 days, how many drinks did you usually have altogether? By a drink we mean a can or glass of beer, a 4-ounce glass of wine, a 1-1/2 ounce shot of liquor, or a mixed drink with 1-1/2 ounces of liquor? Check one.

1 or 2 Drinks Per Day	3 or 4 Drinks Per Day	5 or 6 Drinks Per Day	7 or 8 Drinks Per Day	9 - 11 Drinks Per Day	12 or more Drinks Per Day
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5

3. During the past 30 days, how often have you had 5 or more drinks of alcohol in a row, that is, within a couple of hours (e.g. 2-4 hours)? Check one.

Daily	Nearly Every Day	3 or 4 Times A Week	Once or Twice A Week	2 or 3 Times A Month	Once A Month	Never
☐ 6	☐ 5	☐ 4	☐ 3	☐ 2	☐ 1	☐ 0

4. Please check “Yes” or “No” for each question.

a. ☐ 1 Yes ☐ 2 No **Have you ever used marijuana?**
If you used this drug, have you used it within the past 6 months?
☐ 1 Yes ☐ 2 No

b. ☐ 1 Yes ☐ 2 No **Have you ever used cocaine (powder, crack, or freebase)?**
If you used this drug, have you used it within the past 6 months?
☐ 1 Yes ☐ 2 No

c. ☐ 1 Yes ☐ 2 No **Have you ever used heroin?**
If you used this drug, have you used it within the past 6 months?
☐ 1 Yes ☐ 2 No

d. ☐ 1 Yes ☐ 2 No **Have you ever used amphetamines (speed)?**
If you used this drug, have you used it within the past 6 months?
☐ 1 Yes ☐ 2 No

5. Are you <u>currently</u> in methadone treatment? ☐ 1 Yes ☐ 2 No
If Yes, skip to Question H.

If No, have you <u>ever</u> been in methadone treatment? ☐ 1 Yes ☐ 2 No

H. These last questions ask about your background.

1. What is the highest level of education you have completed? (check one)

☐ 0 11th grade or less

☐ 1 High school graduate or GED

☐ 2 2 years of college / AA degree / Technical school training

☐ 3 College graduate (BA or BS)

☐ 4 Master's degree

☐ 5 Doctorate / medical degree / law degree

2. What is (are) the most likely way(s) that you became infected with HIV? (check "Yes" or "No" for <u>each</u> question.)

a. Sex with a man who was HIV+

☐ 1 Yes ☐ 2 No

b. Sex with a woman who was HIV+

☐ 1 Yes ☐ 2 No

c. Shared needles with a person who was HIV+

☐ 1 Yes ☐ 2 No

d. Blood transfusion or other medical procedure

☐ 1 Yes ☐ 2 No

e. Don't know

☐ 1 Yes ☐ 2 No

f. Other (needle stick at work, etc.)

☐ 1 Yes ☐ 2 No

Please specify: _____

3. Do you work for pay outside the home? ☐ 1 Yes ☐ 2 No

4. Do you have any children? ☐ 1 Yes ☐ 2 No

If <u>Yes</u>, how many live with you? ☐☐

I. The following questions ask about symptoms you might have had during the past four weeks. Please check the box that describes how much you have been bothered by each symptom.

		I DO NOT HAVE THIS SYMPTOM	I HAVE THIS SYMPTOM AND …			
			It doesn't bother me	It bothers me a little	It bothers me a lot	It bothers me terribly
1.	Fatigue or loss of energy?	0	1	2	3	4
2.	Fevers, chills or sweats?	0	1	2	3	4
3.	Feeling dizzy or lightheaded?	0	1	2	3	4
4.	Pain, numbness or tingling in the hands or feet?	0	1	2	3	4
5.	Trouble remembering?	0	1	2	3	4
6.	Nausea or vomiting?	0	1	2	3	4
7.	Diarrhea or loose bowel movements?	0	1	2	3	4
8.	Felt sad, down or depressed?	0	1	2	3	4
9.	Felt nervous or anxious	0	1	2	3	4
10.	Difficulty falling or staying asleep?	0	1	2	3	4
11.	Skin problems, such as rash, dryness or itching?	0	1	2	3	4
12.	Cough or trouble catching your breath?	0	1	2	3	4
13.	Headache?	0	1	2	3	4
14.	Loss of appetite or a change in the taste of food?	0	1	2	3	4

15.	Bloating, pain or gas in your stomach?	0	1	2	3	4
16.	Muscle aches or joint pain?	0	1	2	3	4
17.	Problems with having sex, such as loss of interest or lack of satisfaction?	0	1	2	3	4
18.	Changes in the way your body looks, such as fat deposits or weight gain?	0	1	2	3	4
19.	Problems with weight loss or wasting?	0	1	2	3	4
20.	Hair loss or changes in the way your hair looks?	0	1	2	3	4

Thank you very much for completing these questions.
The information that you provided will help with the development of better drug regimens for all patients with HIV.

PLEASE NOTE: Section "I" on this questionnaire was developed by Amy Justice and Linda Rabaneck. To cite this 20-item symptom index, please contact Dr. Amy Justice at Amy.Justice@med.va.gov.