Date:		Self	Interviewer	<u>Both</u>
Patient ID:	How Admini	istered? <b>è</b> 1	<b>è</b> 2	<b>è</b> 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 <u>All Sure</u>	Somewhat <u>Sure</u>	Very <u>Sure</u>	Extremely <u>Sure</u>
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.

	riease circle one response for each question.	Very <u>Dissatisfied</u>	Some <u>Dissat</u>		ewhat isfied	Very <u>Satisfied</u>
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	<u>A Little</u>	<u>Somewhat</u>	<u>A Lot</u>	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 <u>NOT</u> taken <u>any</u> medications within the <u>past month</u>, please check this box and skip to Section D. C 1

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

Please circle one response for each question.

		<u>Never</u>	<u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>	
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.

applicable

1		
e	5	Within the past week
è	4	1-2 <b>weeks</b> ago
è	3	2-4 weeks ago
è	2	1-3 months ago
è	1	More than 3 months ago
è	0	Never skip medications or not

#### E. In the past week how often did you:

Please circle one response for each question.

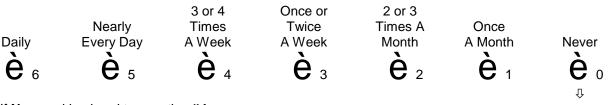
	Please circle one response for each question.	Nev or/			Maathian
		Never/ <u>Rarely</u>	<u>Sometimes</u>	<u>Often</u>	Mostly or <u>Always</u>
1.	Feel like you couldn't shake off the blues even with help from your family or friends?	0	1	2	3
2.	Have trouble keeping your mind on what you were doing?	0	1	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 past month, how often have you:

Please circle one response for each question.

		<u>Never</u>	Almost <u>Never</u>	<u>Sometimes</u>	Fairly <u>Often</u>	Very <u>Often</u>
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.

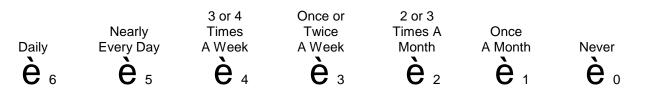


If **Never**, skip ahead to question **#4**.

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.



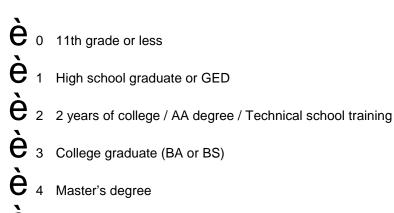
3. During the past 30 days, how often have you had 5 or more drinks of alcohol in a row, that is, within a couple of hours (e.g. 2-4 hours)? Check one.



4. Please check "Yes" or "No" for each question.

a. <b>È</b> 1 Yes <b>È</b> 2 No	Have you ever used marijuana? If you used this drug, have you used it within the past 6 months? $\dot{e}_1$ Yes $\dot{e}_2$ No
b. <b>È</b> 1 Yes <b>È</b> 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? $\dot{e}$ 1 Yes $\dot{e}$ 2 No
c. <b>È</b> 1 Yes <b>È</b> 2 No	Have you ever used heroin? If you used this drug, have you used it within the past 6 months? $\dot{e}_1$ Yes $\dot{e}_2$ No
d. <b>È</b> 1 Yes <b>È</b> 2 No	Have you ever used amphetamines (speed)? If you used this drug, have you used it within the past 6 months? $\dot{e}_1$ Yes $\dot{e}_2$ No
<ol> <li>Are you <u>currently</u> in methadone t If Yes, skip to Question H.</li> </ol>	reatment? <b>È</b> 1 Yes <b>È</b> 2 No
<b>If No</b> , have you <u>ever</u> been in metha	done treatment? <b>È</b> 1 Yes <b>È</b> 2 No

- H. These last questions ask about your background.
- 1. What is the highest level of education you have completed? (check one)



- **e** 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 each question.)
  - a. Sex with a man who was HIV+
    - **e** 1 Yes **e** 2 No
  - b. Sex with a woman who was HIV+



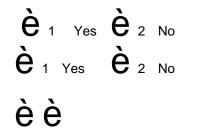
e

1

- c. Shared needles with a person who was HIV+
  - Yes **e** 2 No
- d. Blood transfusion or other medical procedure

е	1	Yes	е	2	No
e. Don'		-	•		
е	1	Yes	е	2	No
•	•	edle stic			
e	1	Yes	e	2	No
Please	spe	ecify:			

- 3. Do you work for pay outside the home?
- 4. Do you have any children?
  - 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	1? 0	1	2	3	4
4.	Pain, numbness or tingling the hands or feet?	in O	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	d? 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 rasl dryness or itching?	n, O	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

AC	ACTG Adherence Baseline Questionnaire							
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.

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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.