CIS # _____
Case Mgr _____

Medications Adherence Checklist

Date ___/___/___
Circle ONE: Pre-test 6-month

At this time, do you have any medications that your doctor or health care provider has prescribed for you? (either for HIV, or any other condition) (check ONE)?

_____ YES _____ NO (do not complete the rest of the survey)

Most people have trouble taking their medications exactly as their doctors prescribe them all the time. Let's try to identify some of the reasons that might make it hard for you, either now or in the future.

Check all that apply, count and enter the total count of checked boxes in the TOTAL row.

	1. Do you have a pillbox? (check if "no")
	2. Do you have a refrigerator? (check if "no")
	3. Do you have a watch with a beeper or other type of alarm system that you can set to go off when it's time for your medications? (check if "no")
	4. Do you have someone who is supportive or helpful to you in taking your medications, a family member, partner, friend or someone else? (check if "no")
	5. Do you feel that if others know you're taking medications, they'll think worse of you, even if they don't know what the medications are for? (check if "yes")
	6. Are you afraid that if others know you have to take some medications, that they'll know you have HIV before you want them to know? (check if "yes)
	7. Do you feel that taking your medications will remind others that you have HIV and they'll think worse of you for having HIV? (check if "yes")
	8. Are you opposed to taking medications for a philosophical, spiritual or religious reason? (check if "yes")
	9. Are you afraid that your medications will cause bad side effects? (check if "yes")
	10. Do you feel uncomfortable around doctors, nurses, or other health care providers, or by being in a medical clinic? (check if "yes")
	11. Do you ever feel that your emotional or mental state (like your mood, or nerves) gets in the way of you taking your medications? (check if "yes")
	12. Do you think your medications are necessary? (check if "no")
	13. Do you feel overwhelmed by the number of pills you have to take? (check if "yes")
	14. Do you feel that your doctor or other health care provider can't treat you effectively because he or she doesn't understand your culture or cultural background? (check if "yes")
	15. Do you feel comfortable with how your doctor or health care provider relates to your gender, your sexual orientation or ethnic identity? (check if "no")
	16. Do you have a permanent place to live? (check if "no")
	17. Does alcohol or drug use ever interrupt or interfere with you taking your medications (like if it makes you forget to take your medications)? (check if "yes")
	18. Do you have trouble finding or affording the kinds of foods you're supposed to take with your medications? (check if "yes")
	19. Do you currently experience side effects from your medications that make it difficult to keep taking the medications? (check if "yes")

Medications Adherence Checklist

	20. Do you have a way to get to your doctor, health care provider and your pharmacy (or other place you pick up your medications)? (check if "no")
	21. Do you feel that it takes too long to get to your doctor or pharmacy or other place you pick up your medications? (check if "yes")
	22. Does your doctor or health care provider have convenient hours for your schedule? (check if "no")
	23. Does your pharmacy or location where you pick up your medications have convenient hours for your schedule? (check if "no")
	24. If your pharmacy or other medications pick-up location does not deliver medications to you, would it make a big difference in your ability to get your medications if it did deliver? (check if "yes")
	25. When you need to see your doctor or health care provider, can you get an appointment in a timely manner? (check if "no")
	26. Do you feel that your dose schedule interferes too much with your work or other life activities? (check if "yes")
	27. Do you have trouble physically taking pills or pills of a certain size, or any other problem getting your medications down? (check if "yes")
	28. Do you have medical insurance (either public or private) for your care? (check if "no")
	29. Do you have insurance or government coverage for your medications? (check if "no")
	30. If you are insured, do you have trouble making your co-payments? (check if "yes")
	31. Is your ADAP/insurance coverage currently pending (i.e. you don't have it yet, but you've applied) ? (check if "yes")
	32. Do you have trouble making and sticking to a budget? (check if "yes")
	33. If you can't afford your medications, has your doctor or another health care professional ever talked you about programs from pharmaceutical companies that might be able to help pay for your medications? (check if "no")
	34. Do your doctor and pharmacist speak a language you can understand well? (check if "no")
	35. In your native language, do you have trouble reading or understanding everything you read? (check if "yes")
	36. Do you know how to take your medications? (check if "no")
	37. Do you think it's important to take your medications correctly? (check if "no")
	38. Do you have trouble remembering to take your medications? (check if "yes")
	TOTAL