Help your medical provider choose the right medications for you

Medications can help you live well with HIV, but only if you take them when you are supposed to—on time, every time. Complete this form and share it with your medical provider. This information can help him/her better understand you, and your lifestyle. Then, you can work together to decide what HIV medications might be right for you.

About You

What language do you prefer to speak? ☐ English ☐ Spanish ☐ Other: _____

What is your current living situation?
☐ Stable housing *(house, apartment, etc.)* ☐ Transitional housing *(shelter, halfway house, etc.)*
☐ I'm staying with a friend(s) ☐ I'm homeless
☐ Other: _____

Whom do you live with most of the time? *(check all that apply)*
☐ I live alone ☐ Partner or spouse
☐ Parent(s)/Grandparent(s) ☐ Children that I am responsible for
☐ Other family members ☐ Friend(s)/Roommate(s)
☐ Other: _____

Who is aware of your HIV status? *(check all that apply)*
☐ I haven't told anyone yet—Do you plan on telling someone? ☐ Yes ☐ No ☐ Unsure
☐ Partner/Spouse ☐ Parent(s)/Grandparent(s)
☐ Other family members ☐ Children that I am responsible for
☐ Friend(s)/Roommate(s) ☐ Other: _____

Is anyone supportive of helping you live with HIV? ☐ No ☐ Yes—Who? _____
(talking with you about your feelings, taking you to appointments, etc.)

How many meals do you have each day? _____

Are your eating habits consistent? ☐ No ☐ Yes

Do you have a refrigerator to store your medications if needed? ☐ No ☐ Yes

Are you a smoker? ☐ No ☐ Yes

Do you use alcohol or other substances? ☐ No ☐ Yes—Alcohol Drinks per week: _____
☐ Yes—Other substances Times per week: _____

What other medications are you using, including those on an as-needed basis?
Prescription medications: _____
Over-the-counter medications: _____
Herbal products: _____

Have you ever been diagnosed with liver or kidney disease? ☐ No ☐ Yes

Do you have a history of heart disease? ☐ No ☐ Yes—Conditions: _____

Does anyone in your family have a history of heart disease? ☐ No ☐ Yes—Conditions: _____

Have you ever been diagnosed with a mental health disorder? ☐ No ☐ Yes—Conditions: _____

Does anyone in your family have a mental health disorder? ☐ No ☐ Yes—Conditions: _____

Have you ever been diagnosed with depression? ☐ No ☐ Yes—Conditions: _____

Have you ever been diagnosed with other conditions/infections? ☐ No ☐ Yes—Conditions: _____

Do you have trouble sleeping or relaxing? ☐ No ☐ Yes—Conditions: _____

Do you have trouble concentrating on tasks? ☐ No ☐ Yes—Conditions: _____

Have you ever suffered from anxiety attacks? ☐ No ☐ Yes
(sudden panic, loss of breath, fast heartbeat, etc.)

How would you rate the amount of stress in your life? *(please circle)* Low Stress 1 2 3 4 5 6 7 8 9 10 High Stress

How do you relieve stress in your life: _____

over ➔

For Women

Are you currently sexually active with a male partner? ☐ No ☐ Yes

Have you considered having a baby? ☐ No ☐ Yes

Have you ever had an unplanned pregnancy? ☐ No ☐ Yes

Work Information

☐ I don't work (*go to the next section)*

What type of work do you do? ☐ Office/Professional ☐ Computer/IT/Technical ☐ Medical/Dental
☐ Customer Service ☐ Retail/Restaurant ☐ Factory/Machinery Worker
☐ Other: _____

When do you work? ☐ Days (8:00 am to 5:00 pm) ☐ Nights (5:00 pm to midnight)
☐ Late Night (midnight to 8:00 am) ☐ I work two or more shifts/jobs

How many hours a day do you work? ☐ 0 to 4 hours per day ☐ 5 to 8 hours per day ☐ 8 to 12 hours per day ☐ It varies

My work schedule is: ☐ The same every week ☐ Different week-to-week

How many days a week do you typically work? *(please circle)* 1 2 3 4 5 6 7 ☐ It varies

School Information

☐ I don't go to school *(go to the next section)*

What is your school schedule? ☐ Full time ☐ Part time

When are your classes? ☐ Day classes ☐ Night classes ☐ Both

If you are in school, how many days a week do you attend classes? *(please circle)* 1 2 3 4 5 6 7

Concerns You Have *(check all that apply)*

☐ How effective and reliable the medication is
☐ What will happen if I miss a dose or stop taking my medications for a while (forget to take on a trip, forget to renew my prescription, etc.)
☐ Side effects I might have
☐ Will the meds change the way I look
☐ The medication won't work
☐ How much the medication will cost
☐ Other: _____

Answer these questions if you are currently taking HIV medications, or have taken HIV meds in the past

Are you currently taking HIV medications? ☐ Yes ☐ Not now, but I have in the past

What medications? _____ _____ _____ _____

_____ _____ _____ _____

If you are currently taking HIV medications, how many times have you missed a dose in the past month? _____ ☐ I don't remember

If you have taken HIV medications in the past, when did you stop? Month: _____ Year: _____ ☐ I don't remember

Why did you stop? _____

What were your most recent CD4 and viral load counts? CD4: _____ Viral Load: _____ ☐ I don't remember

When was the date of your last resistance test? ☐ Genotype ☐ Phenotype Month: _____ Year: _____ ☐ I don't remember

Have you ever changed HIV regimens? ☐ No ☐ Yes—When? _____ ☐ I don't remember