

SUPPLEMENTAL ANTEPARTUM ADHERENCE QUESTIONNAIRE

NIAID ADULT AIDS CLINICAL TRIALS GROUP

Patient Number Date of Patient Visit
mmm dd yyyy

Protocol Number Institution Code

Form Week * Seq. No. ** Step No. Key Operator Code

INSTRUCTIONS:

Please answer the following questions by placing a "✓" in the appropriate box.

1. Did you plan to get pregnant? Yes No
1 2

(Check one)

	Never	Within the last week	Within the last 2-4 weeks	More than 1 month ago	Not prescribed by my provider	
2. When was the last time you missed taking your prenatal vitamins?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	

Please read the statements below and place a "✓" in the appropriate box to show how much you agree or disagree with each one.

(Check one)

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Don't Know	Does Not Apply	
3. Taking HIV medications in pregnancy can help keep HIV from being passed to the baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4		
4. Taking HIV medications in pregnancy might harm the baby.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4		
5. The HIV medications that you are taking make you healthier.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4	8	
6. If you do not take HIV medications properly the medications won't work as well.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	0	1	2	3	4		



SUPPLEMENTAL ANTEPARTUM ADHERENCE QUESTIONNAIRE Page 3 of 5

Pt. No. * Seq. No. ** Step No. Date
mmm dd yyyy

(Check one)

	Strongly Disagree	Somewhat Disagree	Somewhat Agree	Strongly Agree	Does Not Apply
7. Your friends or family members help you remember to take your medications.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> <input type="checkbox"/> 8
8. Your friends and family are supportive of you.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> <input type="checkbox"/> 8
9. Your partner is supportive of you.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> <input type="checkbox"/> 8
10. You have a good understanding of HIV disease.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 8
11. You have a good understanding of how HIV medications work.	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> <input type="checkbox"/> 8



SUPPLEMENTAL ANTEPARTUM ADHERENCE QUESTIONNAIRE Page 4 of 5

Pt. No. * Seq. No. ** Step No. Date
mmm dd yyyy

People may miss taking their HIV medications for various reasons. Here is a list of possible reasons why you may have missed taking any HIV medications. If a reason does not apply to you, check **Never**.

12. In the **past 30 days**, how often have you missed taking your medications because you:

(Check one)

	Never	Rarely	Some-Times	Often	
a. Were away from home?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
b. Were busy with other things?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
c. Simply forgot?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
d. Had too many pills to take?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
e. Wanted to avoid side effects?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
f. Did not want others to notice you taking medication?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
g. Had a change in daily routine?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
h. Felt like the HIV medication was harmful to you?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
i. Fell asleep/slept through dose time?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
j. Felt sick or ill?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
k. Felt depressed/overwhelmed?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
l. Ran out of pills?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
m. Felt healthy, so thought I didn't need them?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
n. Were overwhelmed caring for other family members?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
o. Had trouble paying for HIV medications?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
p. Were worried that the HIV medications might hurt your baby?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
q. Your medication was lost or stolen?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>
r. Were throwing up?	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/>

13. Of all the choices above (a-r), what is the MAIN reason that you didn't take your medication?



SUPPLEMENTAL ANTEPARTUM ADHERENCE QUESTIONNAIRE Page 5 of 5

Pt. No. * Seq. No. ** Step No. Date
mmm dd yyyy

14. In the **past 30 days**, have you used any of the following to help you remember to take your HIV medications?

	Used?		If Used, Was It Helpful?	
	Yes <input type="checkbox"/>	No <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	1	2	1	2
a. Pill boxes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Beepers:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Timers/Programmable wrist watch:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Connecting taking HIV medications with routine activities (meals, brushing teeth, etc.):	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Phone contact with study staff:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Other, specify:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Specify [30]: _____

Language:
English

