

Are you new to taking antiretroviral medicines?

HIV medications do not cure HIV, but they are helpful in saving lives. Although they can be difficult to take, with the right treatment plan, you can stay on course with taking your medications. These questions will assist your healthcare provider in customizing the best treatment plan for you and your lifestyle.

Review this form with your healthcare provider when you discuss your treatment options.

NAME _____ **DATE** _____

Daily Schedule:

- 1 Are your days typically the same from one day to another? Yes No
- 2 How often do you travel? Weekly Monthly Rarely Never
- 3 How often do you work? Full-time Part-time I don't work
- 4 When do you work? Days Nights Varied schedule I don't work
- 5 Are you a primary caregiver to children or the elderly? Yes No

Patient History:

- 6 What date did you have your first positive test? _____
- 7 What date did you have your last negative test? _____ Does not apply
- 8 What prompted you to get tested? Random/routine test Experiencing symptoms
- 9 Are you currently experiencing any symptoms you attribute to HIV? Yes No
- 10 If **YES**, please list them below:

11 Please mark if any of the following apply to you:

Condition	Yes	No
Do you have high cholesterol or does it run in your family?		
Do you have heart disease or does it run in your family?		
Do you have high blood pressure or does it run in your family?		
Do you have diabetes or does it run in your family?		
Do you have liver disease (hepatitis or cirrhosis)?		
Do you have kidney disease?		
Do you have a history of psychiatric disorders or mental illness?		
Do you have a sleeping disorder?		
Are you a smoker?		
Do you consume alcohol?		
Do you use recreational drugs?		

- 12 If you are a woman, are you or do you plan on becoming pregnant? Yes No Does not apply
- 13 Do you consistently use birth control? Yes No
- 14 If **YES**, please list the method(s) you use below:

Treatment:

- 15 Please list any current medications you are taking, including prescription medicines/herbals/vitamins/over-the-counter antacids or other medicines below:

- 16 Have you ever taken any antiretroviral medications for any reason (even briefly) Yes No
- 17 If **YES**, please list the medications and the conditions you were taking them for below:

- 18 What concerns you about starting HIV therapy?
 Side effects Costs Privacy Ability to take medicines regularly
 Other (please explain) _____
- 19 What questions do you have about starting antiretroviral therapy?

