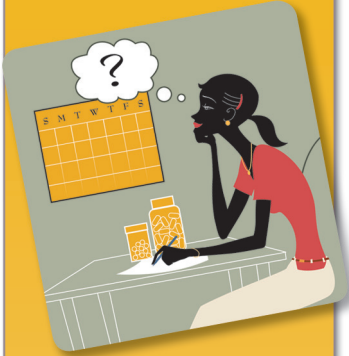


# HIV meds: Are you ready to start?



Your answers to these questions will help your healthcare provider customize the best treatment plan for you and your lifestyle.

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

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## Daily Schedule

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

## Patient History

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

- 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?		

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

## Treatment

- List below any meds you are currently taking, including prescription medicines/herbals/vitamins/over-the-counter antacids or any other medicines:  
\_\_\_\_\_  
\_\_\_\_\_
- Have you ever taken any antiretroviral medications for any reason (even briefly)  Yes  No
- If **YES**, please list the medications and the conditions you were taking them for below:  
\_\_\_\_\_  
\_\_\_\_\_
- What concerns you about starting HIV therapy?  
 Side effects  Costs  Privacy  Ability to take medicines regularly  
 Other (please explain)
- What questions do you have about starting antiretroviral therapy?  
\_\_\_\_\_  
\_\_\_\_\_