47075

PATIENT SURVEY

FOR ADMINISTRATIVE USE ONLY. TO BE COMPLETED BY STUDY COORDINATOR.

DATE OF VISIT: ☐☐ / ☐☐ / ☐☐ PATIENT ID: ☐☐☐☐☐☐☐☐☐

REGULAR PROVIDER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

SITE OF VISIT: ○ Cleveland ○ Houston ○ Manhattan ○ Pittsburgh

Thank you for agreeing to participate in our study. The following survey should take about 20 minutes to complete. Please answer all of the questions to the best of your ability. If you have any questions, please ask the study coordinator who gave you this survey. When finished, return the survey to the study coordinator.

MEDICATIONS: Most people with HIV have many pills to take at different times during the day, and find it hard to always remember their pills. Please tell us what you are doing. Don't worry about telling us that you don't take all your doses. We need to know what is really happening, not what you think we "want to hear." Please fill in ● the circle of the one response that best describes how you take your medications

1. Do you take any medicine to treat your HIV infection? ○ **Yes** ○ **No**

2. During the past 4 days, on how many days have you missed taking any of your doses?

None	**One Day**	**Two Days**	**Three Days**	**Four Days**
○	○	○	○	○

Most anti-HIV medications need to be taken on a schedule, such as "2 times a day," or "three times a day," or "every 8 hours."

3. How closely did you follow your specific schedule over the last four days?

Never	**Some of the Time**	**About Half of the Time**	**Most of the Time**	**All of the Time**
○	○	○	○	○

4. Did you miss any of your anti-HIV medication last weekend--last Saturday or Sunday? ○ **Yes** ○ **No**

5. When was the last time you missed any of your HIV medications?

Within the Past Week	**1-2 wks. Ago**	**2-4 wks. Ago**	**1-3 mos. Ago**	**Over 3 mos. Ago**	**Never Skipped**
○	○	○	○	○	○

6. Do you take any prescription medicine to treat other medical problems you may have? ○ **Yes** ○ **No**

7. When was the last time you missed any of your medication for other medical problems you may have?

Within the Past Week	**1-2 wks. Ago**	**2-4 wks. Ago**	**1-3 mos. Ago**	**Over 3 mos. Ago**	**Never Skipped**
○	○	○	○	○	○

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47075

HEALTH HABITS: **Please fill in the circle of the one response that best describes your health habits.**

8. Do you exercise? ○ **Never** ○ **< Once a Week** ○ **1-2 Times a Week** ○ **3 or More Times a Week**

9. Have you used any of the following therapies in the past year to treat your disease?

	Yes	No		Yes	No
Special Diet	○	○	Acupunture	○	○
Massage	○	○	Meditation/Prayer	○	○
Vitamins	○	○	Homeopathic Medications	○	○
Herbs/Natural Remedies	○	○			

	Past	Present	Never	
10. Do you smoke cigarettes?	○	○	○	
11. Do you drink alcohol?	○	○	○	*If never, please go to question 22*

12. How often do you have a drink containing alcohol?
○ **Never** ○ **Monthly or less** ○ **2 to 4 times a month** ○ **2 to 3 times a week** ○ **4 or more times a week**

13. How many drinks containing alcohol do you have on a typical day when you are drinking?
○ **1 or 2** ○ **3 or 4** ○ **5 or 6** ○ **7 to 9** ○ **10 or more**

14. How often do you have 6 or more drinks on one occasion?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

15. How often during the last year have you found that you were not able to stop drinking once you had started?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

16. How often during the last year have you failed to do what was normally expected from you because of drinking?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

17. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

18. How often during the last year have you had a feeling of guilt or remorse after drinking?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

19. How often during the last year have you been unable to remember what happened the night before because you had been drinking?
○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

20. Have you or someone else been injured as a result of your drinking?
○ **No** ○ **Yes, but not in the last year** ○ **Yes, during the last year**

21. Has a relative or friend or doctor or other health care worker been concerned about your drinking or suggested you cut down?
○ **No** ○ **Yes, but not in the last year** ○ **Yes, during the last year**

Please continue on the next page

47075

22. Do you use illegal drugs? ○ **Past** ○ **Present** ○ **Never** *If never, please go to question 30*

23. How often do you take illegal drugs?

○ **Never** ○ **Monthly or less** ○ **2 to 4 times a month** ○ **2 to 3 times a week** ○ **4 or more times a week**

24. How often during the last year have you found that you were not able to stop taking illegal drugs once you had started?

○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

25. How often during the last year have you failed to do what was normally expected

○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

26. How often during the last year have you had a feeling of guilt or remorse after using drugs?

○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

27. How often during the last year have you been unable to remember what happened the night before because you had been using drugs?

○ **Never** ○ **Less than monthly** ○ **Monthly** ○ **Weekly** ○ **Daily or almost daily**

28. Have you or someone else been injured as a result of your drug use?

○ **No** ○ **Yes, but not in the last year** ○ **Yes, during the last year**

29. Has a relative or friend or doctor or other health care worker been concerned about your drug use?

○ **No** ○ **Yes, but not in the last year** ○ **Yes, during the last year**

30. In the past 4 weeks, have you ever been without a permanent address that you call home? ○ Yes ○ No

31. Have you ever been without a permanent address that you call home? ○ Yes ○ No

REGULAR PROVIDER: **Please fill in the circle of the one response that best describes your regular doctor or nurse in this Infectious Disease clinic.**

	Strongly Disagree					**Strongly Agree**
32. I go to this doctor for almost all of my medical care	○	○	○	○	○	○
33. This doctor handles emergencies	○	○	○	○	○	○
34. This doctor can take care of almost any medical problem I might have	○	○	○	○	○	○
35. I could go to this doctor for help with a personal or emotional problem	○	○	○	○	○	○
36. I could go to this doctor for care of an ongoing problem, such as high blood pressure	○	○	○	○	○	○
37. I go to this doctor for a check-up to prevent illness	○	○	○	○	○	○
38. This doctor and I have been through a lot together	○	○	○	○	○	○
39. This doctor understands what is important to me regarding my health	○	○	○	○	○	○
40. This doctor clearly understands my health needs	○	○	○	○	○	○
41. This doctor always takes my beliefs and wishes into account in caring for me	○	○	○	○	○	○

	Strongly Disagree					Strongly Agree
42. This doctor knows whether or not I eat right, smoke, drink alcohol or use drugs	○	○	○	○	○	○
43. This doctor knows a lot about me as a person (such as my family, home, etc.)	○	○	○	○	○	○
44. I can easily talk about personal things with this doctor	○	○	○	○	○	○
45. Sometimes, this doctor does not listen to me	○	○	○	○	○	○
46. This doctor always explains things to my satisfaction	○	○	○	○	○	○
47. Sometimes, with this doctor, I don't bring up things that I'm worried about	○	○	○	○	○	○
48. I don't always feel comfortable asking questions of this doctor	○	○	○	○	○	○
49. Sometimes, I feel like this doctor ignores my concerns	○	○	○	○	○	○
50. If I am sick, I would always contact someone in this clinic first	○	○	○	○	○	○
51. My medical care improves when I see the same doctor that I have seen before	○	○	○	○	○	○
52. It is very important to me to see my regular doctor in this clinic	○	○	○	○	○	○
53. I rarely see the same doctor when I come to this clinic	○	○	○	○	○	○
54. I can call this doctor if I have a concern and am not sure I need to see a doctor	○	○	○	○	○	○
55. This doctor knows when I'm due for a visit	○	○	○	○	○	○
56. This doctor keeps track of all my health care	○	○	○	○	○	○
57. This doctor always follows up on a problem I've had, either at my next visit or by phone	○	○	○	○	○	○
58. I have tremendous trust in this doctor	○	○	○	○	○	○
59. I would recommend this doctor	○	○	○	○	○	○
60. This doctor always has my best interests at heart	○	○	○	○	○	○
61. This doctor takes responsibility for helping me get all the health care I need	○	○	○	○	○	○
62. I am confident this doctor will act as my advocate	○	○	○	○	○	○
63. This doctor looks out for my interests in dealing with the VA	○	○	○	○	○	○
64. This doctor helps me weigh the pros and cons of my health care decisions	○	○	○	○	○	○
65. This doctor knows a lot about my family	○	○	○	○	○	○
66. This doctor understands how my family affects my health	○	○	○	○	○	○
67. This doctor always follows my visits to other health care providers	○	○	○	○	○	○
68. This doctor helps me interpret my lab tests, x-rays or visits to other doctors	○	○	○	○	○	○
69. This doctor communicates with the other health providers I see	○	○	○	○	○	○
70. This doctor does not always know about care I have received at other places	○	○	○	○	○	○

	Under 3 months	3-6 months	6-12 months	1-2 years	3-4 years	5-6 years	Over 6 years
71. How long have you been a patient of this doctor?	○	○	○	○	○	○	○

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	0 visits	1 visit	2 visits	3 visits	4 visits	5 visits	6 visits	7+ visits
72. In the last 6 months, how many visits have you had to this doctor? (including this visit)	○	○	○	○	○	○	○	○
73. In the last 6 months, how many visits have you had to other people in this clinic?	○	○	○	○	○	○	○	○
74. In the last 6 months, how many visits have you had to doctors outside of this clinic?	○	○	○	○	○	○	○	○
75. In the last 6 months, how many visits have you had to doctors outside of the VA?	○	○	○	○	○	○	○	○

76. SYMPTOMS: **The following questions ask about symptoms you might have had during the past four weeks. Please fill in the circle of the one response that best describes how much you have been bothered by each symptom.**

		I have this symptom and.....			
	I do not have this symptom	It doesn't bother me	It bothers me a little	It bothers me	It bothers me a lot
Fatigue or loss of energy?	○	○	○	○	○
Fevers, chills or sweats?	○	○	○	○	○
Feeling dizzy or lightheaded?	○	○	○	○	○
Pain, numbness, or tingling in the hands or feet?	○	○	○	○	○
Trouble remembering?	○	○	○	○	○
Nausea or vomiting?	○	○	○	○	○
Diarrhea or loose bowel movements?	○	○	○	○	○
Felt sad, down, or depressed?	○	○	○	○	○
Felt nervous or anxious?	○	○	○	○	○
Difficulty falling or staying asleep?	○	○	○	○	○
Skin problems, such as rash, dryness, or itching?	○	○	○	○	○
Cough or trouble catching your breath?	○	○	○	○	○
Headache?	○	○	○	○	○
Loss of appetite or a change in the taste of food?	○	○	○	○	○
Bloating, pain, or gas in your stomach?	○	○	○	○	○
Muscle aches or joint pain?	○	○	○	○	○
Problems with having sex, such as loss of interest or lack of satisfaction?	○	○	○	○	○
Changes in the way your body looks, such as fat deposits or weight gain?	○	○	○	○	○
Problems with weight loss or wasting?	○	○	○	○	○
Hair loss or changes in the way your hair looks?	○	○	○	○	○

Please continue on the next page

These questions ask you for your views about your health. This information will help keep track of how you feel and how well you are able to do your usual activities. Please answer each question by filling in the ● circle. If you are unsure about how to answer, please give the best answer you can.

	Excellent	Very Good	Good	Fair	Poor
77. In general, would you say your health is	○	○	○	○	○

The following items are about activities you might do during a typical day. Does your health now limit you in these areas? If so, how much?

	Yes, Limited A lot	Yes, Limited A Little	No, Not Limited At All
78. Moderate activities, such as moving a table, pushing a vacuum cleaner or bowling	○	○	○
79. Climbing several flights of stairs	○	○	○

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

80. Accomplished less than you would like	○ Yes	○ No
81. Were limited in the kind of work or other activities	○ Yes	○ No

During the past 4 weeks, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

82. Accomplished less than you would like	○ Yes	○ No
83. Didn't do work or other activities as carefully as usual	○ Yes	○ No

84. During the past 4 weeks, how much did pain interfere with your normal work (including both work outside the home and housework)?

○ Not at all ○ A little bit ○ Moderately ○ Quite a bit ○ Extremely

These questions are about how you feel and how things have been with you during the past 4 weeks. For each question, please give the one answer that comes closest to the way you have been feeling.

	All of the Time	Most of the Time	A Good Bit of the	Some of the Time	A Little of the Time	None of the time
85. Have you felt calm and peaceful?	○	○	○	○	○	○
86. Did you have a lot of energy?	○	○	○	○	○	○
87. Have you felt downhearted and blue?	○	○	○	○	○	○
88. During the past 4 weeks, to what extent has your physical health or emothional problems interfered with your social activities (like visiting with friends, relatives, etc.)?	○	○	○	○	○	○

Please continue on the next page

89. For each of these statements, please indicate how often you felt this way during the past week.

	Rarely or none of the time (under 1 day)	Some or a little of the time (1-2 days)	Moderately or much of the time (3-4 days)	Most or almost all of the time (5-7 days)
I was bothered by things that usually don't bother me	○	○	○	○
I had trouble keeping my mind on what I was doing	○	○	○	○
I felt that everything I did was an effort	○	○	○	○
I felt depressed	○	○	○	○
I felt hopeful about the future	○	○	○	○
I felt fearful	○	○	○	○
My sleep was restless	○	○	○	○
I was happy	○	○	○	○
I felt lonely	○	○	○	○
I could not get "going"	○	○	○	○

90. During the past year to what extent did you feel the following emotions?

	Not at All	A little	Somewhat	Quite a bit	Very much
Excited	○	○	○	○	○
Distressed	○	○	○	○	○
Upset	○	○	○	○	○
Scared	○	○	○	○	○
Enthusiastic	○	○	○	○	○
Alert	○	○	○	○	○
Inspired	○	○	○	○	○
Nervous	○	○	○	○	○
Determined	○	○	○	○	○
Afraid	○	○	○	○	○

91. Please tell me how much you agree with the following.

	Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
In most ways, my life is close to my ideal	○	○	○	○	○
The conditions of my life are excellent	○	○	○	○	○
I am satisfied with my life	○	○	○	○	○
So far, I have gotten the important things I want in life	○	○	○	○	○
If I could live my life over, I would change almost nothing	○	○	○	○	○

Thank You