

STARTING TREATMENT

Name: _____ Date: _____

HIV MEDS

ARE YOU READY TO START?



Review this form with your healthcare provider to create the best treatment plan for you and your lifestyle.

Daily Schedule

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you days typically the same from one day to another? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. How often will you be traveling? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. How often do you work? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. When do you work? | <input type="checkbox"/> | <input type="checkbox"/> |

Patient History

5. When did you test positive for HIV?
6. Are you currently experiencing HIV symptoms? Yes No
7. If yes, list them below:

- | | Yes | No |
|--|--------------------------|--------------------------|
| 8. Please mark if any of the following apply to you: | | |
| Do you have high cholesterol or does it run in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have heart disease or does it run in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have high blood pressure or does it run in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have diabetes or does it run in your family? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have liver disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have kidney disease? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have a history of mental illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have trouble sleeping? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you smoke? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you drink alcohol? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you use drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. If female, are you or do you plan on becoming pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Do you use any form of birth control? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. If yes, list the methods below: | | |

Treatment

12. List below any medications that you are currently taking. (This includes prescriptions, over the counter medication, vitamins, or herbs.)

- | | Yes | No |
|--|--------------------------|--------------------------|
| 13. Are you currently experiencing HIV symptoms? | <input type="checkbox"/> | <input type="checkbox"/> |

14. If yes, list the medications taken and the condition it was taken for:

15. What concerns do you have about starting HIV treatment?

16. What questions do you have about starting HIV treatment?

IF YOU NEED ADDITIONAL SPACE, USE BACK OF FORM.

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For more information visit:

www.friendsofaids.org