

Medication Adherence

Please answer the following questions about this medicine: _____ (specify) **OR**
 about medicines you take for this condition: _____ (specify).

Please respond to each question or statement by marking one box per row.

		Less than once per day	Once per day	Twice per day	Three or more per day	
MedAdFRQ	How many times per day are you supposed to take this medicine?.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	
		Strongly Disagree	Disagree	Neither Agree or Disagree	Agree	Strongly Agree
MedAd1	I know how to take this medicine as recommended	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
MedAd2	I understand why I need to take this medicine.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
MedAd3	I believe it is important to take this medicine.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
MedAd4	I believe this medicine is working.....	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
	In the past 7 days ...	Never	Rarely	Sometimes	Almost Always	Always
MedAd5	I took this medicine as recommended	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5
MedAd6	I remembered to take this medicine	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> 3	<input type="checkbox"/> 4	<input type="checkbox"/> 5

In the past 7 days ...		Never	Rarely	Sometimes	Almost Always	Always
MedAd7	<p>I did not take this medicine because it caused side effects that bothered me</p> <p><i>Note: Please select “Never” if you have no side effects.</i></p>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
MedAd8	<p>I stopped taking this medicine because I thought I did not need it.....</p>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
MedAd9	<p>I did not take this medicine because of the cost.....</p>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
		Not at all	A little bit	Somewhat	Quite a bit	Very much
GP5	<p>I am bothered by the side effects of treatment.....</p> <p><i>Note: Please select “Not at all” if you have no side effects.</i></p>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1
FT12	<p>The cost of my medicine has been a financial hardship to my family and me.....</p>	<input type="checkbox"/> 5	<input type="checkbox"/> 4	<input type="checkbox"/> 3	<input type="checkbox"/> 2	<input type="checkbox"/> 1