REDOSE Participant Type

Please complete the survey below.

Thank you!

Participant	◯ Living with HIV ◯ Not Living with HIV
Visit Date	______________________
REDOSE Participant ID	______________________ (e.g. RDS-CW-001, 002 etc for OTC; RDS-SP-001, 002 etc for SPH)
Have you participated in the CARMA study before?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

REDOSE Vaccinations and Viruses

Please complete the survey below.

Thank you!

The questions in this clinical survey will review medical history, current medications, and ARV regimens. This first section asks about certain vaccinations and viruses that are of interest to this study.

Question	Options
Have you ever received the HPV* (human papilloma virus) vaccine? Select one. *HPV - the human papilloma virus is a sexually transmitted virus that causes cervical cancer	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, when? Select one.	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer
Have you ever had Chicken Pox (includes natural infection or receiving the vaccine)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from natural infection (chicken pox) or did you receive the vaccine? Select one.	◯ Natural infection (chicken pox) ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you have Chicken Pox (includes natural infection or receiving the vaccine)? Select one.	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer
Have you ever had Shingles (natural infection or the vaccine)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from a natural infection (shingles) or a vaccine? Select one.	◯ Natural infection (shingles) ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you have Shingles (includes natural infection or receiving the vaccine)? Select one.	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer

Have you ever had Hepatitis B (includes natural infection or receiving the vaccine)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Was it from natural infection or did you receive the Hepatitis B vaccine? Select one.	◯ Natural Infection ◯ Vaccine ◯ Don't know ◯ Prefer not to answer
If yes, when did you get the Hepatitis B vaccine or natural infection? Select one.	◯ Infant (birth to 2 years of age) ◯ Child (2 to 12 years of age) ◯ Adolescent (12 to 21 years of age) ◯ Adult (21+) ◯ Don't know ◯ Prefer not to answer

REDOSE Non-HIV Medications

Please complete the survey below.

Thank you!

Are you currently taking opiates*? (e.g. codeine, morphine, hydrocodone, oxycodone, methadone, kadian, T3s, percocet, percodan, etc.) Select one. *Prescription opiates are used mostly to treat moderate to severe pain.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, are you prescribed your opiates?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, what opioid(s) are you taking?	___________________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer".)
If yes, what is your opiate dosage?	___________________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer".)
Do you currently take any of the following vitamins or supplements regularly? Selecct all that apply.	☐ NONE ☐ Calcium ☐ Iron/ferritin ☐ Multi-vitamins ☐ Vitamin B12 ☐ Vitamin D ☐ Other, please specify: _______
Please specify "Other"	___________________________________
Have you taken any medications in the past 3 months? (non-HIV medications only) Includes antibiotics, insulin, heart medications, antidepressants, hormonal imbalances , steroids, seizure medications, smoking cessation methods, pain medications, puffers for asthma or COPD, etc. Please include medications that you take regularly or occasional use.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	___________________________________

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthritis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Erectile dysfunction
- ◯ Low testosterone
- ◯ Benign prostate hypertrophy
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "Other / Multiple conditions"

____

Are you still taking [nhivmeds] ?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

When did you stop [nhivmeds] ?

____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What have you been taking?

____

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	______________________________
Are you still taking [nhivmeds_2] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_2] ?	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	______________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple Conditions"	______________________________
Are you still taking [nhivmeds_3] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_3] ?	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	______________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple Conditions"	____
Are you still taking [nhivmeds_4] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_4] ?	__________________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	__________________________________

What health condition are you taking this medication for?

- ◯ Hepatitis C (Hep C)
- ◯ Asthma
- ◯ Emphysema/COPD
- ◯ Hypothyroidism (under-active thyroid)
- ◯ Hyperthyroidism (overactive thyroid)
- ◯ Adrenal insufficiency (not enough cortisol)
- ◯ Cushing's disease (too much cortisol)
- ◯ Stroke
- ◯ Myocardial infarction / Heart attack
- ◯ Cardiac arrhythmia / Atrial fibrillation
- ◯ Heart failure
- ◯ Peripheral vascular disease
- ◯ Glaucoma
- ◯ Cataracts
- ◯ Osteoporosis / Osteopenia / Decreased bone density
- ◯ Osteoarthritis
- ◯ Rheumatoid arthritis
- ◯ Fractures
- ◯ Insulin resistance / Pre-diabetes / Borderline diabetes
- ◯ Diabetes
- ◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
- ◯ High cholesterol
- ◯ High blood pressure / Hypertension
- ◯ Liver disease (i.e. fatty liver)
- ◯ Liver cirrhosis
- ◯ Inflammatory bowel disease (IBD)
- ◯ Diverticulitis
- ◯ Renal problem / Kidney problem
- ◯ Neuropathy
- ◯ Vitamin B12 deficiency
- ◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
- ◯ Seizures
- ◯ Fibromyalgia
- ◯ Metabolic syndrome
- ◯ Erectile dysfunction
- ◯ Low testosterone
- ◯ Benign prostate hypertrophy
- ◯ Cancer
- ◯ ADHD
- ◯ Anxiety
- ◯ Alcohol addiction / Alcohol use disorder
- ◯ Anorexia nervosa or Bulimia nervosa
- ◯ Bipolar disorder
- ◯ Personality disorder
- ◯ Dementia
- ◯ Depression
- ◯ Drug addiction / Substance use disorder
- ◯ Obsessive-compulsive disorder (OCD)
- ◯ Post traumatic stress disorder (PTSD)
- ◯ Schizophrenia
- ◯ Herpes (HSV)
- ◯ Sleep problems / difficulty sleeping / Insomnia
- ◯ Smoking cessation
- ◯ Pain / chronic pain
- ◯ Iron deficiency
- ◯ Migraines
- ◯ Other / Multiple conditions
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "Other / Multiple Conditions"	____________________
Are you still taking [nhivmeds_5] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_5] ?	____________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	____________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	__________________________________
Are you still taking [nhivmeds_6] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_6] ?	____________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	____________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	____________________
Are you still taking [nhivmeds_7] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_7] ?	____________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	____________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"

____

Are you still taking [nhivmeds_8] ?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

When did you stop [nhivmeds_8] ?

____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What have you been taking?

____

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	__________________________
Are you still taking [nhivmeds_9] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_9] ?	__________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	__________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"

____

Are you still taking [nhivmeds_10] ?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

When did you stop [nhivmeds_10] ?

____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

What have you been taking?

____

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	__________________________________
Are you still taking [nhivmeds_11] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_11] ?	____________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	____________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	__________________________________
Are you still taking [nhivmeds_12] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_12] ?	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	______________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify 'Other / Multiple conditions'	__________________________________
Are you still taking [nhivmeds_13] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_13] ?	__________________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	__________________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"	__________________________________
Are you still taking [nhivmeds_14] ?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you stop [nhivmeds_14] ?	____________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Have you taken any other medications in the past 3 months? (non-HIV medications only)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What have you been taking?	____________________________

What health condition are you taking this medication for?

◯ Hepatitis C (Hep C)
◯ Asthma
◯ Emphysema/COPD
◯ Hypothyroidism (under-active thyroid)
◯ Hyperthyroidism (overactive thyroid)
◯ Adrenal insufficiency (not enough cortisol)
◯ Cushing's disease (too much cortisol)
◯ Stroke
◯ Myocardial infarction / Heart attack
◯ Cardiac arrhythmia / Atrial fibrillation
◯ Heart failure
◯ Peripheral vascular disease
◯ Glaucoma
◯ Cataracts
◯ Osteoporosis / Osteopenia / Decreased bone density
◯ Osteoarthritis
◯ Rheumatoid arthritis
◯ Fractures
◯ Insulin resistance / Pre-diabetes / Borderline diabetes
◯ Diabetes
◯ Deep vein thrombosis (DVT)* / Pulmonary embolism
◯ High cholesterol
◯ High blood pressure / Hypertension
◯ Liver disease (i.e. fatty liver)
◯ Liver cirrhosis
◯ Inflammatory bowel disease (IBD)
◯ Diverticulitis
◯ Renal problem / Kidney problem
◯ Neuropathy
◯ Vitamin B12 deficiency
◯ Peptic ulcer disease / Gastroesophageal reflux disease (GERD) / Reflux
◯ Seizures
◯ Fibromyalgia
◯ Metabolic syndrome
◯ Erectile dysfunction
◯ Low testosterone
◯ Benign prostate hypertrophy
◯ Cancer
◯ ADHD
◯ Anxiety
◯ Alcohol addiction / Alcohol use disorder
◯ Anorexia nervosa or Bulimia nervosa
◯ Bipolar disorder
◯ Personality disorder
◯ Dementia
◯ Depression
◯ Drug addiction / Substance use disorder
◯ Obsessive-compulsive disorder (OCD)
◯ Post traumatic stress disorder (PTSD)
◯ Schizophrenia
◯ Herpes (HSV)
◯ Sleep problems / difficulty sleeping / Insomnia
◯ Smoking cessation
◯ Pain / chronic pain
◯ Iron deficiency
◯ Migraines
◯ Other / Multiple conditions
◯ Don't know
◯ Prefer not to answer

Please specify "Other / Multiple conditions"

____

Are you still taking [nhivmeds_15] ?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

When did you stop [nhivmeds_15] ?

____
(Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)

Have you taken any other medications in the past 3 months? (non-HIV medications only)

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

Please write down any other non HIV medications the participant is taking or has taken in the last 3 months.

____

Have you taken any 'as needed' medication in the past 3 months? If so, for what reasons did you take them? (i.e. taking ibuprofen for headaches.) Please include medications that are prescribed and over the counter.

☐ Pain (ibuprofen/Advil, acetaminophen/Tylenol, etc)
☐ Allergies (Benadryl, Claritin, Aleve, etc)
☐ Sleep (melatonin or other sleep aids)
☐ Dry eyes/eye issues (eye drops)
☐ Viagra, Cialis
☐ Other

Please Specify "Other"

____

Do you take any natural health or herbal products/alternative therapies that you have not mentioned in the "other medication" section?

If yes, please list the therapies you are currently taking below.

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

Please list the natural health or herbal products/ alternative therapies you are currently taking.

____
(If don't know, enter 9999.)

Have you ever used testosterone (intramuscular or subcutaneous injections, topical gels, and oral tablets)?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What type(s) did you use?

☐ Intramuscular injections
☐ Subcutaneous injections
☐ Topical gels
☐ Oral tablets

Have you taken testosterone in the last month?

◯ Yes
◯ No
◯ Don't know
◯ Prefer not to answer

What is the dose?	______________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer".)
For what reasons did you take testosterone?	☐ Low testosterone levels ☐ Well-being ☐ Energy ☐ Libido ☐ Social energy ☐ Body building ☐ Other, please specify: _______ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	______________________________

REDOSE HIV History and Antiretrovirals (ARVs)

Please complete the survey below.

Thank you!

This section covers medical information as it pertains to HIV-related health and well-being such as your potential use of HIV antiretroviral therapy medications (i.e., ARVs) and your viral load and CD4 count.

Question	Response
When were you diagnosed with HIV? dd-mm-yyy Indicate month and year if possible, otherwise year only.	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When were you diagnosed with HIV?	◯ Don't know ◯ Prefer not to answer
Did you acquire HIV through vertical transmission (this means that you acquired HIV from your mother during birth or breastfeeding)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you receive your lowest (nadir) CD4 count results? dd-mm-yyy Indicate month and year if possible, otherwise year only.	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you receive your lowest (nadir) CD4 count results?	◯ Don't know ◯ Prefer not to answer
What was your lowest (nadir) CD4 count? Indicate count: ______ cells/mm3	______________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you able to estimate your lowest (nadir) CD4 count? Select one.	◯ < 200 cells/mm3 ◯ 200 - 500 cells/mm3 ◯ >500 cells/mm3 ◯ Unable to estimate ◯ Prefer not to answer
When did you last receive your most recent CD4 count results? dd-mm-yyyy Indicate month and year if possible, otherwise year only.	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you last receive your CD4 count results?	◯ Don't know ◯ Prefer not to answer

Question	Response
What was your most recent CD4 count results? Indicate count: _______ cells/mm3	______________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you able to estimate your most recent CD4 count? Select one.	◯ < 200 cells/mm3 ◯ 200 - 500 cells/mm3 ◯ >500 cells/mm3 ◯ Unable to estimate ◯ Prefer not to answer
Have you ever had a viral load (VL) over 100,000 copies/mL? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
When did you last receive your most recent HIV viral load results? dd-mm-yyyy Indicate month and year if possible, otherwise year only.	______________________________ (Enter 15 if DAY unknown. Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
When did you last receive your HIV viral load results?	◯ Don't know ◯ Prefer not to answer
What was your most recent viral load, undetectable or detectable? Select one.	◯ Undetectable (i.e. below 40 copies/mL) ◯ Detectable (i.e. over 40 copies/mL) ◯ Don't know ◯ Prefer not to answer
Do you remember the exact result? If so, what was it? Indicate level: _____ copies/mL	______________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Are you currently taking ARVs?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Which ARVs are you currently taking? Select all that apply. [°] = ARVs that are always prescribed with another class of ARVs	☐ 3TC (lamivudine)° ☐ Atripla (efavirenz + FTC + tenofovir) *fixed dose ☐ Biktarvy (bictegravir + TAF + FTC) *fixed dose ☐ Cabenuva (injectable cabotegravir + rilpivirine) ☐ Celsentri (Maraviroc)° ☐ Combivir (3TC + AZT)° *fixed dose ☐ Complera (FTC + Tenofovir + Rilpivirine) *fixed dose ☐ Delstrigo (doravirine + 3TC + tenofovir) *fixed dose ☐ Descovy (FTC + TAF)° ☐ Dovato (dolutegravir + lamivudine) *fixed dose ☐ Edurant (rilpivirine)° *fixed dose ☐ Fuzeon (enfuvirtide, T-20)° *fixed dose ☐ Genvoya (elvitegravir + cobicistat + TAF + FTC) *fixed dose ☐ Intelence (etravirine)° ☐ Isentress (Raltegravir)° ☐ Juluca (dolutegravir + rilpivirine) *fixed dose ☐ Kaletra (lopinavir + ritonavir)° ☐ Kivexa (abacavir + lamivudine)° *fixed dose ☐ Norvir (ritonavir)° ☐ Odefsey (TAF + FTC + rilpivirine) *fixed dose ☐ Pifeltro (doravirine)° *fixed dose ☐ Prezcobix (darunavir + cobicistat)° ☐ Prezista (darunavir)° ☐ Retrovir (AZT, zidovudine)° ☐ Reyataz (atazanavir)° ☐ Rukobia (Fostemsavir)° *fixed dose ☐ Stribild (elvitegravir + cobicistat + TDF + FTC) *fixed dose ☐ Sunlenca (lenacapavir)° ☐ Sustiva (efavirenz) *fixed dose ☐ Tivicay (Dolutegravir)° ☐ Trizivir (ABC + 3TC + AZT)° *fixed dose ☐ Triumeq (dolutegravir + 3TC + abacavir) *fixed dose ☐ Truvada (FTC + tenofovir)° *fixed dose ☐ Viramune (nevirapine)° ☐ Viread (tenofovir)° *fixed dose ☐ Ziagen (abacavir)° ☐ Other, please specify: ____________________ ☐ Don't know ☐ Prefer not to answer
Please specify "Other": ________	__________________________________
What is your dosage for 3TC?	◯ 1x 150mg white diamond tablet (BID) ◯ 1x 300mg grey diamond tablet (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	__________________________________
What is your dosing interval for Cabenuva?	◯ Oral lead in ◯ Initiation (SC) ◯ Monthly (SC-maintenance) ◯ Every 2 months (SC-maintenance) ◯ Don't know

What is your dosage for maraviroc?	◯ 1x 150mg blue oval tablet (BID) ◯ 1x 300mg blue oval tablet (BID) ◯ 2x 300mg blue oval tablet (BID) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
What is your dosage for Descovy?	◯ 1x 200mg;10mg white rectangular tablet (OD) ◯ 1x 200mg;25mg blue rectangular tablet (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
What is your dosage for etravirine?	◯ 2x 100mg white oval tablet (BID) ◯ 1x 200mg white oval tablet (BID) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
What is your dosage for raltegravir?	◯ 1x 400mg pink oval tablet (BID) ◯ 2x 400mg pink oval tablet (OD) ◯ 2x 600mg yellow oval tablet (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
What is your dosage for Kaletra?	◯ 2x fixed dose yellow oval tablet (BID) ◯ 3x fixed dose yellow oval tablet (BID) ◯ 4x fixed dose yellow oval tablet (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
What is your dosage for ritonavir?	◯ 1x 100mg white oval tablet (OD) ◯ 1x 100mg white oval tablet (BID) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________
How is your dosage for Prezcobix?	◯ 1x fixed dose pink oval tablet (OD) ◯ 1x fixed dose pink oval tablet (BID) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	________________________________

What is the dosage for darunavir?	◯ 1x 600mg orange oval tablet (BID) ◯ 1x 800mg red oval tablet (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	______________________________
What is your dosage for Retrovir?	◯ 3x 100mg white capsule (BID) ◯ 2x 100mg white capsule (TID) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	______________________________
What is your dosage for atazanavir?	◯ 1x 300mg blue/red capsule (OD) ◯ 2x 200mg blue capsule (OD) ◯ Other: ________ ◯ Don't know
Please specify "Other": ________	______________________________
What is your dosing interval for lenacapavir?	◯ Oral lead in first 2 days ◯ Oral lead in 8th day ◯ Day 15 SC ◯ Every 6 months SC (maintenance) ◯ Don't know
What is your dosage for dolutegravir?	◯ 1x 50mg yellow circular tablet (OD) ◯ 1x 50mg yellow circular tablet (BID) ◯ Other: __________ ◯ Don't know
Please specify "Other": ________	______________________________
What is your dosage for nevirapine?	◯ 2x 200mg yellow oval tablet (OD) ◯ 1x 200mg yellow oval tablet (BID) ◯ Other: __________ ◯ Don't know
Please specify "Other": ________	______________________________
What is your dosage for abacavir?	◯ 1x 300mg yellow oval tablet (BID) ◯ 2x 300mg yellow oval tablet (OD) ◯ Other: __________ ◯ Don't know
Please specify "Other": ________	______________________________

REDOSE Medical History

Please complete the survey below.

Thank you!

This section covers medical information as it pertains to your general health and well-being, including conditions you may be living with. We will go through a list of different health diagnoses, and then there will be a text box at the end to add anything that was not included. Please indicate any that you have been diagnosed with by a healthcare provider whether in the present or past.

Have you ever been told by a doctor or nurse that you have hepatitis C (Hep C)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you taken any medication for hepatitis C? Select one. Medications include: Interferon, Intron, Peg-Intron, Virazole, Remeron, Rebetron, Ribavirin, Epclusa, Maviret, Harvoni, Zepatier	◯ Yes ◯ No ◯ No, but spontaneously cleared ◯ Don't know ◯ Prefer not to answer
Which medication for hepatitis C did you take? Select one.	◯ Interferon ◯ Direct Acting Antivirals (Epclusa, Maviret, Harvoni, Zepatier) ◯ Don't know ◯ Prefer not to answer
Were you cured? Select one.	◯ Yes, I do not currently have hepatitis C ◯ Yes, but then I got hepatitis C again after that ◯ No ◯ Don't know ◯ Prefer not to answer
Have you been told by a doctor or nurse that you have hepatitis B (Hep B)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever taken medication for hepatitis B? Select one. Medications include: lamivudine, emtricitabine, entecavir, adefovir, tenofovir (TAF or TDF)	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have asthma? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication (including inhalers) to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Has a doctor ever told you that you have emphysema/COPD (is a long-term, progressive disease of the lungs that primarily causes shortness of breath due to over-inflation of the alveoli (air sacs in the lung)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have hypothyroidism (underactive thyroid)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have hyperthyroidism (overactive thyroid)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have adrenal insufficiency (not enough cortisol)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have Cushing's disease (too much cortisol)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have had a stroke? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have coronary artery disease or have had myocardial infarction / heart attack? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have cardiac arrhythmia / atrial fibrillation / abnormal heart rhythm? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have heart failure? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have peripheral vascular disease*? Select one. *when blocked / narrowed arteries reduce blood flow to your limbs.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have glaucoma*? Select one. *condition of increased pressure within the eyeball, causing gradual loss of sight.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Has a doctor ever told you that you have cataracts? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have osteoporosis / osteopenia / low bone density? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take vitamins/supplements for this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have osteoarthritis? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have rheumatoid arthritis? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have had fractures? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
If yes, were any fractures a result of low bone density?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have insulin resistance / pre-diabetes / borderline diabetes? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have diabetes? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Are you currently taking any medications (prescription or non prescription) for your diabetes? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What type of medication? Indicate: _________	______________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Has a doctor ever told you that you have deep vein thrombosis (DVT)* / pulmonary embolism (PE)**? Select one. *DVT is the formation or presence of a blood clot in a blood vessel deep in the body. ** PE is a sudden blockage in a lung artery. It usually happens when a blood clot breaks loose and travels through the bloodstream to the lungs.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have high cholesterol? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Has a doctor ever told you that you have high blood pressure / hypertension? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have liver disease or fatty liver? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have liver cirrhosis*? Select one. *severe scarring of the liver that permanently interferes with its function.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have inflammatory bowel disease (IBD) (e.g., Crohn's disease or ulcerative colitis)? Select one. Please note that IBD is different from irritable bowel syndrome (IBS) and is usually diagnosed and treated by a gastroenterology (GI doctor).	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have diverticulitis*? Select one. *the infection or inflammation of pouches that can form in your intestines.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have a renal problem/ kidney problem/ kidney stones? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have neuropathy*? Select one. *damage, disease, or dysfunction of one or more nerves especially of the peripheral nervous system that is typically marked by burning or shooting pain, numbness, tingling, or muscle weakness or atrophy.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have vitamin B12 deficiency? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication/vitamins to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have peptic ulcer disease / gastroesophageal reflux disease (GERD) / acid reflux? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have seizures/ epilepsy? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have fibromyalgia*? Select one. *chronic disorder characterized by widespread musculoskeletal pain, fatigue, and tenderness in localized areas.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have metabolic syndrome? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have Herpes Simplex Virus I / HSV1 / Cold Sores? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication/vitamins to treat this? Select one.	◯ Yes, I take medication to prevent an outbreak ◯ Yes, I take medication to treat an outbreak ◯ Yes, I use cream to treat ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have Herpes Simplex Virus II / HSV 2 / Genital Herpes? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this?	◯ Yes, I take medication to prevent an outbreak ◯ Yes, I take medication to treat an outbreak ◯ Yes, I use cream to treat ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have insomnia / difficulty sleeping? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have an iron deficiency? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication/supplements to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Has a doctor ever told you that you have migraines? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have cancer? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What type(s) of cancer were you diagnosed with? DO NOT READ LIST, MULTIPLE RESPONSES ALLOWED	☐ Anal ☐ Bladder ☐ Bone ☐ Breast ☐ Colon or Rectum ☐ Kaposi Sarcoma ☐ Kidney ☐ Liver ☐ Lung ☐ Lymphoma /leukemia ☐ Oral or pharynx ☐ Prostate ☐ Skin (melanoma, basal, squamous cells) ☐ Stomach or Small Bowel ☐ Testicular ☐ Thyroid ☐ Other, please specify: __________________________ ☐ Don't know /no answer ☐ Prefer not to answer
Please specify "Other"	__________________________
Have you ever undergone any cancer treatment? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Which cancer treatments have you undergone? Select all that apply.	☐ Chemotherapy ☐ Radiation ☐ Surgery (cancer-related) ☐ Other ☐ Don't know ☐ Prefer not to answer
Specify "Other"	__________________________
What part of your body had radiation?	__________________________
What was the surgery?	__________________________

Question	Options
Do you experience any of the following challenges? Select all that apply.	☐ Partial deafness ☐ Complete deafness ☐ Partial blindness ☐ Complete blindness ☐ Physical difficulty to walk - requiring assistive device like cane or walker on regular basis ☐ Physical difficulty to walk - requiring wheelchair on regular basis ☐ Speech difficulty ☐ Physical difficulty moving one or both arms ☐ Other, please specify: ☐ None ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________

The following questions are related to mental health / mind wellbeing. Please indicate whether a health care provider has diagnosed you with any of the following mental health diagnoses. Please remember that your responses are confidential and private. If there is something you prefer not to answer, you are welcome to select "prefer not to answer".

Question	Options
Has a doctor ever told you that you have ADHD (attention deficit hyperactivity disorder)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have ADD (attention deficit disorder)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have anxiety? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have alcohol use disorder*? Select one. *Also known as alcohol addiction	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have anorexia nervosa or bulimia nervosa? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have bipolar disorder? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have personality disorder? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have dementia? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have depression? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Question	Response
Has a doctor ever told you that you have a substance use disorder? Select one. *Also known as drug addiction	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have obsessive-compulsive disorder (OCD)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have post traumatic stress disorder (PTSD)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Has a doctor ever told you that you have schizophrenia? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you take medication to treat this? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever been diagnosed with any other health concerns? Please list any diagnoses that were not listed previously and state whether you are taking any medications for it, and if so, please list what medication you are taking.	__________________________________ (Enter 9999 if none)
In the last 12 months has your weight decreased, increased or has it stayed about the same? Select one.	◯ Decreased ◯ Increased ◯ Stayed about the same ◯ Don't know
Was your weight loss intentional, for example, you were dieting?	◯ Yes ◯ No
Approximately how many pounds or kilograms did you lose over the last 12 months? Select one.	__________________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Please indicate the units from above.	◯ Pounds (lbs) ◯ Kilograms (kgs)
Do you think your weight gain was related to your HIV medications?	◯ Yes ◯ No
Approximately how many pounds or kilograms did you gain over the last 12 months?	____ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
Please indicate the units from above.	◯ Pounds (lbs) ◯ Kilograms (kgs)
Does your health limit you in vigorous activities, such as running, lifting heavy objects, or participating in strenuous sports?	◯ Yes limited a lot ◯ Yes limited a little ◯ No, not limited at all

Congratulations, you have now completed the clinical survey, thank you for your time!

The second part of the study will be the follow-up survey, which is a questionnaire on your demographics, antiretroviral history, experiences with stigma, physical and mental health, and social wellbeing. Your answers to this second questionnaire are very important to helping us better understand the various factors that may affect your health!

This portion of the visit must take place within 14 days of the first visit, and can be completed independently or with a research assistant. Independently, you are free to take breaks in-between sections, and come back to the survey at a later time. With a research assistant, it will be scheduled accordingly and can take place remotely on the phone or online on Zoom. It will take ~1.5hrs to complete and you will receive $40 honoraria. Please let the us know if you prefer to complete this follow-up independently or with a research assistant.

Thank you again for participating in our study!

REDOSE Demographics

Please complete the survey below.

Thank you!

Please select the option that best describes how you are completing this survey.

- ◯ I am completing this survey independently
- ◯ I am completing this survey with a research assistant

Survey Date

____

The questions in this survey have been co-designed by men and women living with HIV. Together, we have tried to make the questions as safe as possible. Your answers are very valuable for understanding and improving the health and wellbeing of people living with HIV. This first section includes questions on gender, sexual orientation, income, education, and housing. Let's begin!

What was your biological sex at birth? Select one.

*Intersex people are individuals born with any of several variations in sex characteristics including chromosomes, testicles/ovaries, sex hormones or genitals that, according to the UN Office of the High Commissioner for Human Rights, "do not fit the typical definitions for male or female bodies"

- ◯ Female
- ◯ Male
- ◯ Intersex*
- ◯ Undetermined
- ◯ Other, please specify: _______
- ◯ Don't know
- ◯ Prefer not to answer

Please specify "Other"

____

With respect to your gender, how do you currently identify? Select all that apply.

(Gender refers to socially constructed roles, behaviors, expressions, and identities associated with being female, male, or gender diverse. It influences how individuals perceive themselves and others, how they behave, and the distribution of power and resources in society. Gender identity is not limited to a binary (girl/woman, boy/man) and can change over time, existing along a continuum.)

*Two-Spirit is a term specific only to Indigenous peoples

*Intersex people are individuals born with any of several variations in sex characteristics including chromosomes, testicles/ovaries, sex hormones or genitals that, according to the UN Office of the High Commissioner for Human Rights, "do not fit the typical definitions for male or female bodies"

- ☐ Woman (cis-gender)
- ☐ Man (cis-gender)
- ☐ Trans Man (assigned female sex at birth, identifies as a man)
- ☐ Trans Woman (assigned male sex at birth, identifies as a woman)
- ☐ Two-Spirit*
- ☐ Intersex*
- ☐ Gender Queer
- ☐ Non-binary
- ☐ Other, please specify: ________
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

____

In research, we often have to group individuals together if there are too few people in one group to avoid possible identification. By doing this, we continue to acknowledge that there is great diversity within these groups and acknowledge that this approach may feel like our identities are being erased. We will do our best to preserve what you have identified in the question above. Of the listed gender identities, which would you be most comfortable being grouped as, if needed?	◯ Woman ◯ Man ◯ Non-binary (including genderfluid, gender queer, agender) ◯ Unsure/questioning/undecided ◯ None of the above. I prefer to self-describe my gender identity as: ______ ◯ Prefer not to answer
Please specify your self-described gender identity:	__________________________________
Which of the following applies to your current situation regarding gender-affirming hormones and/or surgery? Select one.	◯ I have fully medically/surgically transitioned ◯ I am in the process of medically/surgically transitioning ◯ I am planning to transition, but have not begun ◯ I am not planning to medically/surgically transition ◯ The concept of 'transitioning' does not apply to me ◯ I am not sure whether I am going to medically transition ◯ Other, please specify: ______________ ◯ Don't know ◯ Prefer not to answer
Please specify "Other"	__________________________________
Are you currently taking gender-affirming hormones?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
With respect to your sexual orientation, how do you currently identify? Select all that apply. *Asexuality is the lack of sexual attraction to others, or low or absent interest in or desire for sexual activity *Pansexuality, also called omnisexuality, is the sexual, romantic or emotional attraction towards people regardless of their sex or gender identity. Pansexual people may refer to themselves as gender-blind, asserting that gender and sex are not determining factors in their romantic or sexual attraction to others. **Two-Spirit is a term specific only to Indigenous peoples	☐ Heterosexual / Straight ☐ Lesbian ☐ Gay ☐ Bisexual ☐ Queer ☐ Two-spirited** ☐ Questioning ☐ Asexual* ☐ Pansexual* ☐ Other, please specify: __________ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________

In research, we often have to group individuals together if there are too few people in one group to avoid possible identification. By doing this, we continue to acknowledge that there is great diversity within these groups and acknowledge that this approach may feel like our identities are being erased. We will do our best to preserve what you have identified in the question above. Of the sexualities listed below, which would you be most comfortable being grouped as, if needed?	◯ Heterosexual/straight ◯ Gay/Lesbian ◯ Bisexual/Pansexual ◯ Queer ◯ Unsure/Questioning/Undecided ◯ Asexual ◯ None of the above. I prefer to self-describe my sexuality as:_______ ◯ Prefer not to answer
Please specify your self-described sexuality:	__________________________________
What is your date of birth*? *Please enter MONTH and YEAR only; enter 15 for the day.	__________________________________ (Enter 06 if MONTH unknown. Enter 1900 if YEAR unknown.)
Age	__________________________________
Were you born in Canada? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
In what country were you born?	__________________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
In what year did you first come to Canada to live?	__________________________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
What is your current legal status in Canada? Select one. Undocumented/Non-Status/Immigrant*: undocumented: includes people who are living in any country without legal documentation; non-status: includes people who have been waiting for years in the refugee claim process through no fault of their own; those who were unjustly denied refugee status based on arbitrary policies such as designated safe country lists; migrant workers who are fired after a workplace injury or forced to leave the country after a certain time limit or other similarly inhumane rules; those who have fallen through the cracks of an unfair immigration and refugee system; as well as those who have remained undocumented for many years.	◯ Canadian citizen ◯ Landed Immigrant/Permanent Resident ◯ Refugee/Protected Person* ◯ Refugee claimant/Person in need of protection* ◯ Here with Temporary Work Papers* ◯ Here with Humanitarian and Compassionate approval ◯ Here as a visitor ◯ Here on a Student Visa ◯ Undocumented/Non-Status/Immigrant* ◯ Other, please specify: ______________ ◯ Don't know ◯ Prefer not to answer
Please specify "Other"	__________________________________

What is your current legal relationship status? Select one. "Common-law" means you are living with a person who you are not legally married to, but with whom you are in a relationship with, and to whom at least one of the following situations applies: They have been living with you in a spouse-like relationship for at least 12 continuous months. They are the parent of your child by birth or adoption. They have custody and control of your child (or had custody and control immediately before the child turned 19 years of age) and your child is wholly dependent on that person for support.	◯ Single ◯ In a relationship, not living together ◯ In a relationship, living together (but not legally married or common-law)* ◯ Common-law ◯ Legally married ◯ Separated/Divorced ◯ Widowed ◯ Other, please specify:__________ ◯ Don't know ◯ Prefer not to answer
Please specify "Other"	__________________________________
What do you consider to be your racial and/or ethnic background? Select all that apply.	☐ Arab (e.g., Egyptian, Kuwaiti, and Libyan) ☐ Black African (e.g., Nigerian, Somali) ☐ Black Caribbean (e.g., Haitian) ☐ Black Other (e.g., Black Canadian) ☐ Central Asian (e.g., Kazakhstan, Krgyzstan, Tajikistan, Turkmenistan) ☐ Chinese or Taiwanese ☐ Filipino ☐ Indigenous Person from a country outside of Canada ☐ Indigenous person living in Canada (e.g., First Nations, Métis, and Inuit) ☐ Japanese ☐ Korean ☐ Latin American (e.g., Chilean, Costa Rican, Mexican) ☐ Multiple races / Multiracial / "Mixed" ☐ South Asian (e.g., Indian, Bangladeshi, Pakistani, Punjabi, and Sri Lankan) ☐ Southeast Asian (e.g.,Cambodian, Laotian, Malaysian, Vietnamese) ☐ West Asian (e.g. Iraqi, Isreali, Lebanese, Afghani, Iranian) ☐ White ☐ Other, please specify: ____________________ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________
In research, we often have to group individuals together if there are too few people in one group to avoid possible identification. By doing this, we continue to acknowledge that there is great diversity within these groups and acknowledge that this approach may feel like our identities are being erased. We will do our best to preserve what you have identified in the question above. Of the races and ethnicities listed below, which would you be most comfortable being grouped as if needed?	◯ Asian ◯ Black ◯ Indigenous ◯ Latin American ◯ White ◯ Unsure/questioning/undecided ◯ Mixed ethnicity ◯ None of the above. I prefer to self-describe my race or ethnicity as: ______ ◯ Prefer not to answer
Please specify your self-described ethnicity:	__________________________________

What is the highest level of formal education you have completed? Select one. GED*: The General Education Development test allows adults who didn't complete their high school curriculum to earn a high school equivalency diploma. CEGEP*: It's an acronym from the French term Collège D'enseignement General et Professionnel, which means General and professional teaching college. In Quebec, it's a public school that provides the first level of post-secondary education.	◯ No formal education ◯ Some Elementary / Grade school ◯ Completed Elementary / Grade school ◯ Some High school / Secondary / GED ◯ Completed High school / Secondary / GED* ◯ Some Trade or Technical training ◯ Completed Trade or Technical training ◯ Some CEGEP* / College / University ◯ Completed CEGEP / College / University ◯ Other, please specify: __________ ◯ Don't know ◯ Prefer not to answer
Please specify "Other"	______________________________
Are you currently employed? Employment includes any work at a job that is paid work, and includes people who have a job but are not at work due to maternity leave or illness. Select all that apply.	☐ Yes, I have a paid job, where income tax is deducted ☐ Yes, I have a paid job, but no income taxes are deducted ☐ Yes, I am self-employed ☐ No, I am not currently employed ☐ I am a student ☐ I do volunteer work ☐ I am currently on disability insurance ☐ Other, please specify: _____________ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	______________________________
In the last year, have you received social assistance from welfare or PWD (person with disability)? In British Columbia, welfare is known as BC Employment and Assistance (BCEA). Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Considering all income sources (i.e. Pension (including federal CPPD, Private LTD, or other sources), Sex work, Selling drugs / drugs paraphernalia, Pan-handling/ 'squeegeeing' / recycling, Personal Savings, Loan(s) / Student Loan(s), Parent / friend / relative / partner income, Honoraria (workshops, trainings), Money from First Nations Band) how much does YOUR HOUSEHOLD make in a year, before taxes (i.e. household gross yearly income)? Please do not include income sources from gifts/lotteries. Select one.	◯ Less than $10,000 ◯ $10,000 to $19,999 ◯ $20,000 to $29,999 ◯ $30,000 to $39,999 ◯ $40,000 to $49,999 ◯ $60,000 to $69,999 ◯ $70,000 to $79,999 ◯ $80,000 to $99,999 ◯ $100,000 or more ◯ Don't know ◯ Prefer not to answer

Considering all income sources (i.e. Pension (including federal CPPD, Private LTD, or other sources), Sex work, Selling drugs / drugs paraphernalia, Pan-handling/ 'squeegeeing' / recycling, Personal Savings, Loan(s) / Student Loan(s), Parent / friend / relative / partner income, Honoraria (workshops, trainings), Money from First Nations Band) how much do YOU make in a year, before taxes (i.e. personal gross yearly income)? Select one.	◯ Less than $10,000 ◯ $10,000 to $19,999 ◯ $20,000 to $29,999 ◯ $30,000 to $39,999 ◯ $40,000 to $49,999 ◯ $60,000 to $69,999 ◯ $70,000 to $79,999 ◯ $80,000 to $99,999 ◯ $100,000 or more ◯ Don't know ◯ Prefer not to answer
Given your total household income, how difficult is it to meet your monthly housing costs (including rent, mortgage, property taxes, heat, electricity, water and/or gas)? Would you say that it is... Select one.	◯ Not at all difficult ◯ A little difficult ◯ Fairly difficult ◯ Very difficult ◯ Not applicable - Do not have monthly housing costs (homeless, shelter, couch surfing) ◯ Don't know ◯ Prefer not to answer
What are the first 3 digits of the postal code for the place where you are currently living or regularly sleep?	__________________________________ (Enter x0x if "Don't know" or "Prefer not to answer". (CASE SENSITIVE))
Have you ever experienced homelessness*? Select one. *Homelessness is the situation of an individual, family, or community without stable, safe, permanent, appropriate housing, or the immediate means and ability of acquiring it.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you been homeless in the last 6 months? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Do you get income support/subsidy to help pay for your housing? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How safe do you feel in the place where you are currently living or regularly sleep? Select one.	◯ Extremely safe ◯ Somewhat safe ◯ Less than safe ◯ Not safe at all ◯ Don't know ◯ Prefer not to answer
How much do you agree or disagree with the statement: My current housing situation is stable. Select one.	◯ Strongly agree ◯ Somewhat agree ◯ Neither agree or disagree ◯ Somewhat disagree ◯ Strongly disagree ◯ Don't know ◯ Prefer not to answer

REDOSE Medical and HIV

Please complete the survey below.

Thank you!

Have you or has your healthcare provider discussed the impact of your viral load on the risk of transmitting HIV? Select one.	○ Yes ○ No ○ Don't know ○ Prefer not to answer
How do you think taking ARVs* changes your risk of transmitting HIV? Select one. *ARVs = Antiretroviral medication	○ Makes the risk of transmission a lot lower ○ Makes the risk of transmission a little lower ○ Makes little difference to the risk of transmission ○ Makes the risk of transmission a little higher ○ Makes the risk of transmission a lot higher ○ Don't know ○ Prefer not to answer
Have you heard of U=U*? Select one. U=U*: Undetectable equals Untransmittable	○ Yes ○ No ○ Don't know ○ Prefer not to answer
What does it mean to you?	__________________________________

Undetectable = Untransmittable (U=U) means that when a person living with HIV is taking antiretroviral therapy and has an undetectable viral load in their blood, they cannot transmit HIV to their drug or sex partners.

REDOSE Antiretrovirals (ARVs) and Side Effects

Please complete the survey below.

Thank you!

As part of our study, we hope to look at HIV medication levels in blood and how these change with an individual's sex and age, as this could affect how well the meds work, or their side effects. To properly assess this, the following section asks questions about how you usually take your HIV medications. The reason we will be asking these questions is to understand if the level of medications should be adjusted and these questions are not meant to shame or police medication adherence. This information is completely confidential and will not be shared without your full consent or impact your care in any way. You can choose "prefer not to answer" to any of the questions if you are not comfortable sharing this information. Your participation in this survey will be used to better understand and improve the challenges different sexes face with antiretroviral medications and aging.

In the clinical survey you stated you were taking the following ARVs: [arvb].

How long have you been taking your current combination of antiretrovirals (i.e., HIV medications)?

Please specify whether days, weeks, months, or years, and then enter the number below. (If you have had gaps in your treatment, please list the duration of time since you STARTED your current combination).

Select one.

- ◯ days
- ◯ weeks
- ◯ months
- ◯ years
- ◯ Don't know
- ◯ Prefer not to answer

(Enter number of days, weeks, months, or years below)

Please specify the number of days.

____
(Please enter 9999 if don't know)

Please specify the number of weeks.

____
(Please enter 9999 if don't know)

Please specify the number of months.

____
(Please enter 9999 if don't know)

Please specify the number of years.

____
(Please enter 9999 if don't know)

Are you able to estimate the number of years? Select one.

- ◯ 5-10 years
- ◯ 10-15 years
- ◯ 15+ years
- ◯ Unable to estimate
- ◯ Prefer not to answer

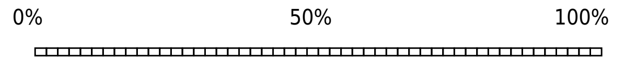
Have you ever stopped taking your antiretrovirals for a period of 3 months or more, since the first time they were prescribed? Select one.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How many times?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6-10 ◯ >10 ◯ Don't know ◯ Prefer not to answer
What are the main reasons you have had a gap in your treatment or stopped taking your antiretrovirals? Select all that apply.	☐ I wanted to stop experiencing side effects that I perceived were from my ARVs ☐ I wanted to lessen the medications I had to take ☐ I felt like I did not need to take them ☐ I had difficulty staying motivated to take my medications due to my mental health ☐ I was advised by my healthcare provider to stop taking my medications for a certain period of time ☐ I had trouble paying for ARVs (elapsed coverage in another country and was unable to pay) ☐ I was travelling for a long time, and it was difficult to keep track of the regimen ☐ I was travelling for a long time, and I did not have access to medications ☐ I was travelling for a long time and I was not permitted to bring my medications into the country ☐ Other, please specify: ______ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	________________________
Were you on other non-HIV medications at the time(s) that you stopped treatment? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
What were the medications and what were they for?	________________________
How many times a day do you currently take 3TC (lamivudine)?	____________________
How many times a day do you currently take Atripla (efavirenz + FTC + tenofovir)?	____________________
How many times a day do you currently take Biktarvy (bictegravir + TAF + FTC)?	____________________
How many times a day do you currently take Celsentri (Maraviroc)?	____________________
How many times a day do you currently take Combivir (3TC + AZT)?	____________________

How many times a day do you currently take Complera (FTC + Tenofovir + Rilpivirine)?	________________
How many times a day do you currently take Delstrigo (doravirine + 3TC + tenofovir)?	________________
How many times a day do you currently take Descovy (FTC + TAF)?	________________
How many times a day do you currently take Dovato (dolutegravir + lamivudine)?	________________
How many times a day do you currently take Edurant (rilpivirine)?	________________
How many times a day do you currently take Fuzeon (enfuvirtide, T-20)?	________________
How many times a day do you currently take Genvoya (elvitegravir + cobicistat + TAF + FTC)?	________________
How many times a day do you currently take Intelence (etravirine)?	________________
How many times a day do you currently take Isentress (Raltegravir)?	________________
How many times a day do you currently take Juluca (dolutegravir + rilpivirine)?	________________
How many times a day do you currently take Kaletra (lopinavir + ritonavir)?	________________
How many times a day do you currently take Kivexa (abacavir + lamivudine)?	________________
How many times a day do you currently take Norvir (ritonavir)?	________________
How many times a day do you currently take Odefsey (TAF + FTC + rilpivirine)?	________________
How many times a day do you currently take Pifeltro (doravirine)?	________________
How many times a day do you currently take Prezcobix (darunavir + cobicistat)?	________________
How many times a day do you currently take Prezista (darunavir)?	________________
How many times a day do you currently take Retrovir (AZT, zidovudine)?	________________

How many times a day do you currently take Reyataz (atazanavir)?	______________________
How many times a day do you currently take Rukobia (Fostemsavir)?	______________________
How many times a day do you currently take Stribild (elvitegravir + cobicistat + TDF + FTC)?	______________________
How many times a day do you currently take Sustiva (efavirenz)?	______________________
How many times a day do you currently take Tivicay (Dolutegravir)?	______________________
How many times a day do you currently take Trizivir (ABC + 3TC + AZT)?	______________________
How many times a day do you currently take Triumeq (dolutegravir + 3TC + abacavir)?	______________________
How many times a day do you currently take Truvada (FTC + tenofovir)?	______________________
How many times a day do you currently take Viramune (nevirapine)?	______________________
How many times a day do you currently take Viread (tenofovir)?	______________________
How many times a day do you currently take Ziagen (abacavir)?	______________________
How many times a day do you currently take [arvboth]?	______________________
At what time of day do you usually take your antiretrovirals? Select all that apply.	☐ morning (4am - noon) ☐ afternoon (noon - 4pm) ☐ evening (4pm - 4am) ☐ variable timing ☐ other, please specify: ________ ☐ don't know ☐ prefer not to answer
Please specify "Other"	______________________ (Please enter 9999 if don't know or 7777 if prefer not to answer)
Do you usually take your antiretrovirals with food? Select one.	◯ Yes ◯ No ◯ Variable ◯ Prefer not to answer

Do you feel you have a safe environment to take and/or store your antiretrovirals? Select one.	◯ Yes, I do have a safe environment ◯ Yes, I do have a safe environment, but I still have some concerns ◯ No, I do not have a safe environment ◯ Don't know ◯ Prefer not to answer
For what reasons do you feel unsafe taking/storing ARVs in your environment? Select all that apply.	☐ Fear of disclosure ☐ Self-stigma ☐ It may get stolen ☐ I experience unstable housing ☐ Other, please specify ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________
We understand that many people on HIV medications find it difficult to take them regularly and often miss doses. It is common to miss some doses. We would like to know how many doses you have missed. Please indicate on the line beside the point showing your best guess about how much medication you have taken in the last month. 0% means you have taken no medication; 50% means you have taken half your medication; 100% means you have taken every single dose of medication	0% 50% 100%  *(Place a mark on the scale above)*
Have you missed any doses of HIV medications in the past week?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

How many doses have you missed?

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
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- ◯ 94
- ◯ 95
- ◯ 96
- ◯ 97
- ◯ 98
- ◯ 99
- ◯ 100
- ◯ Don't know
- ◯ Prefer not to answer

What are the main reasons why you may have missed a dose? Select all that apply.

- ☐ Side effects
- ☐ Too many pills to take
- ☐ ARV drug resistance
- ☐ Drug fatigue* (e.g., tired of taking meds)
- ☐ Forgot/Kept forgetting
- ☐ Stress
- ☐ Drug interactions (e.g., drug interactions between ARVs and other medications)
- ☐ Incarcerated
- ☐ Life challenges (e.g., addiction, unstable housing)
- ☐ Disclosure issues/privacy
- ☐ Depression
- ☐ Moved
- ☐ Travelling outside of Canada/inside Canada
- ☐ Trouble paying for ARVs
- ☐ Trouble picking up ARVs
- ☐ Ran out of meds
- ☐ Don't feel like it
- ☐ Chemsex
- ☐ Other, please specify
- ☐ Don't Know
- ☐ Prefer not to answer

Please specify "Other"

____

Have you ever taken a double dose to make up for any missed doses of HIV medication, or if you forgot you had taken it already and took it again? Select one. Please note: taking a double dose is not recommended by healthcare providers, we would just like to know how often people practice this.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you taken a double dose of medication in the past week?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever reduced your medication dose (e.g., reducing by half or taking every other day)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you reduced your medication over the past week? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How often do you reduce your medication dose? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
For what reasons did you reduce your medication dose? Select all that apply.	☐ To reduce side effects ☐ Insufficient medications until my refill (late refill) ☐ Trouble paying for ARVs ☐ Shared my ARVs with a partner/family who is also HIV positive ☐ Other, please specify: ______ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________
Did your side-effects improve after reducing your medications? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

What ARV side effects did you experience IN THE PAST, whether diagnosed by a healthcare provider or not? Select all that apply.

- ☐ NONE
- ☐ Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)
- ☐ Diarrhea, gas and bloating
- ☐ Emotional and mental problems (foggy thinking, memory loss, nightmares)
- ☐ Fatigue (not made better by resting)
- ☐ Stomach aches or pain
- ☐ Headaches
- ☐ Mouth and throat problems (tingling, inflammation, blisters)
- ☐ Muscles aches and pain
- ☐ Nausea, vomiting, appetite loss
- ☐ Nerve pain and numbness
- ☐ Rash, skin, hair, nail problems
- ☐ Sexual difficulties (libido or sex drive, sexual functioning)
- ☐ Sleep problems (insomnia, falling asleep, staying asleep)
- ☐ Gallstones
- ☐ Kidney stones
- ☐ Other (please specify)____________
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

____

What ARV side effects do you CURRENTLY experience, whether diagnosed by a healthcare provider or not? Select all that apply.

- ☐ NONE
- ☐ Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)
- ☐ Diarrhea, gas and bloating
- ☐ Emotional and mental problems (foggy thinking, memory loss, nightmares)
- ☐ Fatigue (not made better by resting)
- ☐ Stomach aches or pain
- ☐ Headaches
- ☐ Mouth and throat problems (tingling, inflammation, blisters)
- ☐ Muscles aches and pain
- ☐ Nausea, vomiting, appetite loss
- ☐ Nerve pain and numbness
- ☐ Rash, skin, hair, nail problems
- ☐ Sexual difficulties (libido or sex drive, sexual functioning)
- ☐ Sleep problems (insomnia, falling asleep, staying asleep)
- ☐ Gallstones
- ☐ Kidney stones
- ☐ Other (please specify)____________
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

____

How often did you experience these side effects during the past 4 weeks?

	Continuously	Several times a day	Daily	A few times a week	A few times a month (1-4 times/month)
...Diarrhea, gas and bloating	○	○	○	○	○
...Emotional and mental problems (foggy thinking, memory loss, nightmares)	○	○	○	○	○
...Fatigue (not made better by resting)	○	○	○	○	○
...Stomach aches or pain	○	○	○	○	○
...Headaches	○	○	○	○	○
...Mouth and throat problems (tingling, inflammation, blisters)	○	○	○	○	○
...Muscles aches and pain	○	○	○	○	○
...Nausea, vomiting, appetite loss	○	○	○	○	○
...Nerve pain and numbness	○	○	○	○	○
...Rash, skin, hair, nail problems	○	○	○	○	○
...Sexual difficulties (libido or sex drive, sexual functioning)	○	○	○	○	○
...Sleep problems (insomnia, falling asleep, staying asleep)	○	○	○	○	○

How much have you been bothered by these side effects in the past 4 weeks?

	It doesn't bother me	It bothers me a little	It bothers me	It bothers me a lot	Prefer not to answer
...Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)	○	○	○	○	○
...Diarrhea, gas and bloating	○	○	○	○	○
...Emotional and mental problems (foggy thinking, memory loss, nightmares)	○	○	○	○	○
...Fatigue (not made better by resting)	○	○	○	○	○
...Stomach aches or pain	○	○	○	○	○
...Headaches	○	○	○	○	○
...Mouth and throat problems (tingling, inflammation, blisters)	○	○	○	○	○
...Muscles aches and pain	○	○	○	○	○
...Nausea, vomiting, appetite loss	○	○	○	○	○
...Nerve pain and numbness	○	○	○	○	○

...Rash, skin, hair, nail problems	◯	◯	◯	◯	◯
...Sexual difficulties (libido or sex drive, sexual functioning)	◯	◯	◯	◯	◯
...Sleep problems (insomnia, falling asleep, staying asleep)	◯	◯	◯	◯	◯
...Gallstones	◯	◯	◯	◯	◯
...Kidney stones	◯	◯	◯	◯	◯
...[arvf_oth]	◯	◯	◯	◯	◯

On the days you experienced these side effects, how much influence did it have on your daily functioning?

	None	Only a bit	Somewhat	Quite a lot	Very much
...Diarrhea, gas and bloating	◯	◯	◯	◯	◯
...Emotional and mental problems (foggy thinking, memory loss, nightmares)	◯	◯	◯	◯	◯
...Fatigue (not made better by resting)	◯	◯	◯	◯	◯
...Stomach aches or pain	◯	◯	◯	◯	◯
...Headaches	◯	◯	◯	◯	◯
...Mouth and throat problems (tingling, inflammation, blisters)	◯	◯	◯	◯	◯
...Muscles aches and pain	◯	◯	◯	◯	◯
...Nausea, vomiting, appetite loss	◯	◯	◯	◯	◯
...Nerve pain and numbness	◯	◯	◯	◯	◯
...Rash, skin, hair, nail problems	◯	◯	◯	◯	◯
...Sexual difficulties (libido or sex drive, sexual functioning)	◯	◯	◯	◯	◯
...Sleep problems (insomnia, falling asleep, staying asleep)	◯	◯	◯	◯	◯

How sure are you that these side effect are caused by your ARVs?

	Very sure	Quite sure	Not very sure	Very unsure
...Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)	◯	◯	◯	◯
...Diarrhea, gas and bloating	◯	◯	◯	◯
...Emotional and mental problems (foggy thinking, memory loss, nightmares)	◯	◯	◯	◯
...Fatigue (not made better by resting)	◯	◯	◯	◯

...Stomach aches or pain	○	○	○	○
...Headaches	○	○	○	○
...Mouth and throat problems (tingling, inflammation, blisters)	○	○	○	○
...Muscles aches and pain	○	○	○	○
...Nausea, vomiting, appetite loss	○	○	○	○
...Nerve pain and numbness	○	○	○	○
...Rash, skin, hair, nail problems	○	○	○	○
...Sexual difficulties (libido or sex drive, sexual functioning)	○	○	○	○
...Sleep problems (insomnia, falling asleep, staying asleep)	○	○	○	○
...Gallstones	○	○	○	○
...Kidney stones	○	○	○	○
...[arvf_oth]	○	○	○	○

Why do you think [Body weight, body shape changes (e.g Lipodystrophy, lipoatrophy, lipohypertrophy)] was caused by your ARVs?

- ☐ I did not experience this symptom before I started taking the drug
- ☐ The symptom started soon after I started taking the drug
- ☐ I experienced this symptom less often before I started taking the drug
- ☐ The symptom was less serious before I started taking the drug
- ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again
- ☐ The symptom went away when I stopped taking the drug
- ☐ The symptom started or grew worse when the drug dosage was increased
- ☐ The symptom decreased or went away when the drug dosage was decreased
- ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this
- ☐ The symptom is described in the patient leaflet
- ☐ Other, please specify: ______

Please specify "Other"

____

Why do you think [Diarrhea, gas and bloating] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________________
Why do you think [Emotional and mental problems (foggy thinking, memory loss, nightmares)] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________________

Why do you think [Fatigue (not made better by resting)] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________
Why do you think [Stomach aches or pain] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________

Why do you think [Headaches] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________________
Why do you think [Mouth and throat problems (tingling, inflammation, blisters)] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________________

Why do you think [Muscles aches and pain] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	______________________________
Why do you think [Nausea, vomiting, appetite loss] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	______________________________

Why do you think [Nerve pain and numbness] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	__________________________________
Why do you think [Rash, skin, hair, nail problems] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	__________________________________

Why do you think [Sexual difficulties (libido or sex drive, sexual functioning)] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	__________________________________
Why do you think [Sleep problems (insomnia, falling asleep, staying asleep)] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	__________________________________

Why do you think [Gallstones] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	______________________________
Why do you think [Kidney stones] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	______________________________

Question	Response
Why do you think [arvf_oth] was caused by your ARVs?	☐ I did not experience this symptom before I started taking the drug ☐ The symptom started soon after I started taking the drug ☐ I experienced this symptom less often before I started taking the drug ☐ The symptom was less serious before I started taking the drug ☐ The symptom went away when I stopped taking the drug and came back when I started taking it again ☐ The symptom went away when I stopped taking the drug ☐ The symptom started or grew worse when the drug dosage was increased ☐ The symptom decreased or went away when the drug dosage was decreased ☐ A healthcare professional (for example a doctor or pharmacist) confirmed this ☐ The symptom is described in the patient leaflet ☐ Other, please specify: ______
Please specify "Other"	________________________________
What actions have you taken in relation to your ARV side effects in the past/present? Select all that apply.	☐ Discussed with my healthcare professional ☐ I stopped taking the drug temporarily by myself ☐ In consultation with my healthcare professional, I stopped taking the drug temporarily ☐ I stopped taking the drug permanently by myself ☐ In consultation with a healthcare professional, I stopped taking the drug permanently ☐ A drug and/or natural health product/ alternative therapy has been prescribed to reduce/relieve the side effect. Please specify ________ ☐ I started using other drugs and/or natural health products/ alternative therapies by myself to reduce/relieve the side effects. Please specify________________ ☐ I reduced the drug dosage to minimize side effects (e.g. taking half or taking every other day) ☐ I have changed parts of my lifestyle to adjust to the side effect ☐ Other, please specify__________ ☐ Don't know ☐ Prefer not to answer
Please specify the drug and/or remedy prescribed	________________________________
Please specify the drug and/or remedy taken	________________________________
Please specify "Other":	________________________________

How satisfied are you with your current HIV treatment? Select one.	◯ Very satisfied ◯ Moderately satisfied ◯ Slightly satisfied ◯ Neutral ◯ Slightly dissatisfied ◯ Moderately dissatisfied ◯ Very dissatisfied ◯ Don't know ◯ Prefer not to answer
How convenient have you been finding your HIV treatment to be recently? Select one.	◯ Very convenient ◯ Moderately convenient ◯ Slightly convenient ◯ Neutral ◯ Slightly inconvenient ◯ Moderately inconvenient ◯ Very inconvenient ◯ Don't know ◯ Prefer not to answer
How satisfied are you with your knowledge and understanding of your HIV? Select one.	◯ Very satisfied ◯ Moderately satisfied ◯ Slightly satisfied ◯ Neutral ◯ Slightly dissatisfied ◯ Moderately dissatisfied ◯ Very dissatisfied ◯ Don't know ◯ Prefer not to answer
What are some ways you would like to expand your knowledge and understanding of your HIV? Please select all that apply.	☐ Connection to more peers/community ☐ Attend informational sessions ☐ Explore informational resources online *we will provide some resources in an email upon survey completion ☐ Have more discussions with your healthcare provider ☐ Get engaged with research ☐ Other, please specify: ______ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________________________
How satisfied are you with the extent to which the HIV treatment fits in with your lifestyle? Select one.	◯ Very satisfied ◯ Moderately satisfied ◯ Slightly satisfied ◯ Neutral ◯ Slightly dissatisfied ◯ Moderately dissatisfied ◯ Very dissatisfied ◯ Don't know ◯ Prefer not to answer
Are you satisfied to continue with your present form of HIV treatment? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Would you prefer to be on a different treatment regimen?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which ARV regimen would you prefer? If you are unsure, what general characteristics of a regimen would be important to you?

____

How much do you agree or disagree with the following statements? Please tick one box for each row.

	Strongly Agree	Agree	Neither agree nor disagree	Disagree	Strongly Disagree	Prefer not to answer
a. I feel that I have choice over the type of ARVs I take.	◯	◯	◯	◯	◯	◯
b. I feel that my healthcare provider explains why I am on a specific ARVs.	◯	◯	◯	◯	◯	◯
c. I feel informed about the ARVs that I take.	◯	◯	◯	◯	◯	◯
d. I am comfortable to discuss side effects of ARVs with my physician or health care team (e.g. pharmacist, NP, nurse etc).	◯	◯	◯	◯	◯	◯
e. I feel that my healthcare providers listen to my concerns of side effects from my ARVs.	◯	◯	◯	◯	◯	◯
f. Overall, I am more satisfied than dissatisfied with my ARVs.	◯	◯	◯	◯	◯	◯
g. I feel I understand the benefits of taking my ARVs in the long term.	◯	◯	◯	◯	◯	◯
h. In the long term, I'm optimistic about the future of my ARVs.	◯	◯	◯	◯	◯	◯

REDOSE Substance Use

Please complete the survey below.

Thank you!

This section will ask about your potential use of alcohol, tobacco, cannabis, and other substances. This includes prescription medications used differently than for which they were prescribed. Your lived experiences are very valuable in helping us understand the factors that affect your health. We understand that some of these questions may be sensitive or difficult to answer. Please know that your responses are completely confidential.

Question	Options
Have you EVER used cigarettes/tobacco, alcohol, or drugs recreationally (non-medicinally)? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Have you ever smoked cigarettes regularly? If so, did you smoke cigarettes within the past 3 months?	◯ Yes, within the last 3 months ◯ Yes, more than 3 months ago ◯ No, never

How old were you when you first started smoking cigarettes?

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◯ 99
◯ 100
◯ Don't know
◯ Prefer not to answer
(Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")

Please specify the frequency of current cigarette use. Select one.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Don't know ◯ Prefer not to answer

Please specify the quantity of current cigarettes smoked [prsnt_freq_pack_yrs].
*In BC, most packs sold have 20 cigarettes.

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◯ Don't know
◯ Prefer not to answer
(cigarettes)

For how long have you smoked [prsnt_qty_pack_yrs] cigarettes [prsnt_freq_pack_yrs] for?

Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question.

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	◯ 70 ◯ 71 ◯ 72 ◯ 73 ◯ 74 ◯ 75 ◯ 76 ◯ 77 ◯ 78 ◯ 79 ◯ 80 ◯ 81 ◯ 82 ◯ 83 ◯ 84 ◯ 85 ◯ 86 ◯ 87 ◯ 88 ◯ 89 ◯ 90 ◯ 91 ◯ 92 ◯ 93 ◯ 94 ◯ 95 ◯ 96 ◯ 97 ◯ 98 ◯ 99 ◯ 100 ◯ Don't know ◯ Prefer not to answer (Specify days/weeks/months/years in the next question)
Please specify the units (days/weeks/months/years) for the previous question from drop-down list.	◯ days ◯ weeks ◯ months ◯ years
Looking at your entire smoking history as a whole, how many times did you abstain from smoking cigarettes for a period of more than 3 months?	◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6-10 ◯ >10 ◯ 0 ◯ Don't know ◯ Prefer not to answer

Considering all of your years smoking since the age that you started, the following questions will ask you for an average of cigarettes daily, weekly, monthly or yearly, whichever applies to you. We're looking for one number that represents your best estimate over this period of time.

Please specify the average frequency of total cigarette use. Select one.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Don't know
◯ Prefer not to answer

Please specify the average quantity of total [pstfreq_pack_yrs1] cigarettes smoked.

*In Canada, most packs sold have 20 cigarettes.

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How many total years have you smoked cigarettes? This does not include years that you stopped or quit smoking.	________________________
How many years has it been since you stopped smoking cigarettes?	________________________
Any additional information not captured above in regards to cigarette smoking?	______________________________
Have you ever drank alcohol? If so, did you drink alcohol within the last 3 months?	◯ Yes, within the last 3 months ◯ Yes, more than 3 months ago ◯ No, never

How old were you when you first started drinking?

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◯ 100
◯ Don't know
◯ Prefer not to answer

Please specify the frequency of current alcohol use.
Select one.

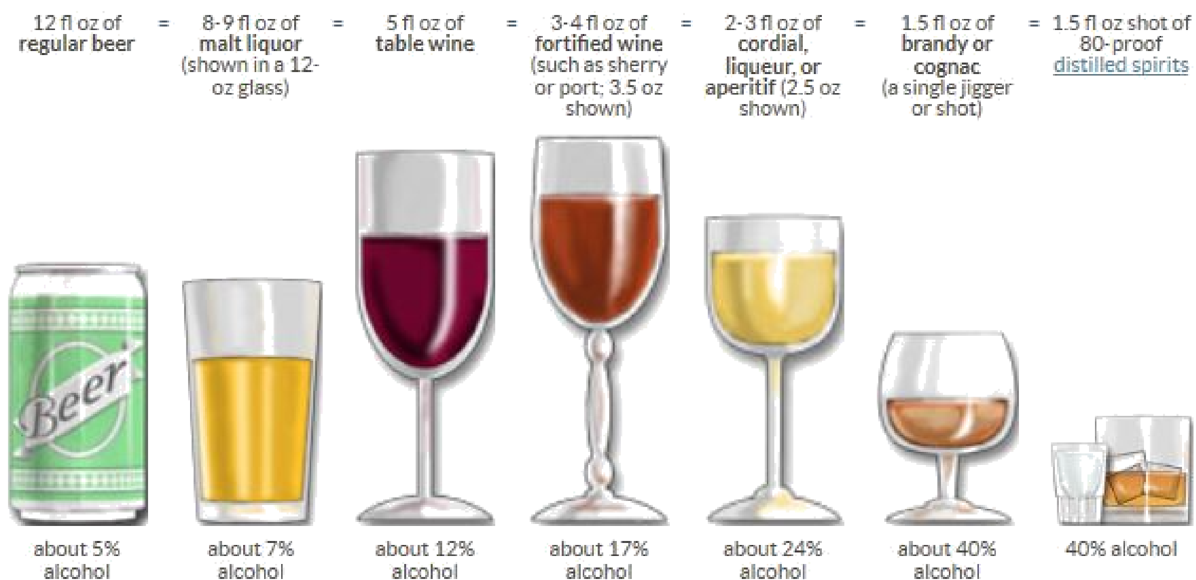
◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Don't know
◯ Prefer not to answer

What's a "standard" drink?

Although the drinks pictured here are different sizes, each contains approximately the same amount of alcohol and counts as one U.S. standard drink or one alcoholic drink-equivalent.

Bottle of Wine = 5 drinks

Bottle of Spirits = 17 drinks



Please specify the quantity of current [prsnt_freq_drnk_yrs] alcohol use

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◯ Don't know
◯ Prefer not to answer
(drinks)

For how long have you drank [prsnt_qty_drnk_yrs] drinks of alcohol [prsnt_freq_drnk_yrs] for?
Just specify NUMBER of (days/weeks/months/years) & specify unit in the next question

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- ◯ 69

	◯ 70 ◯ 71 ◯ 72 ◯ 73 ◯ 74 ◯ 75 ◯ 76 ◯ 77 ◯ 78 ◯ 79 ◯ 80 ◯ 81 ◯ 82 ◯ 83 ◯ 84 ◯ 85 ◯ 86 ◯ 87 ◯ 88 ◯ 89 ◯ 90 ◯ 91 ◯ 92 ◯ 93 ◯ 94 ◯ 95 ◯ 96 ◯ 97 ◯ 98 ◯ 99 ◯ 100 ◯ Don't know ◯ Prefer not to answer (Specify days/weeks/months/years in the next question)
Please specify the units (days/weeks/months/years) for the previous question from drop-down list	◯ days ◯ weeks ◯ months ◯ years

Considering all of your years drinking alcohol between now and the age that you started, we'd like to ask you for an average of drinks daily, weekly, monthly or yearly whichever is accurate for you. We're looking for one number that represents your best estimate over your entire drinking history.

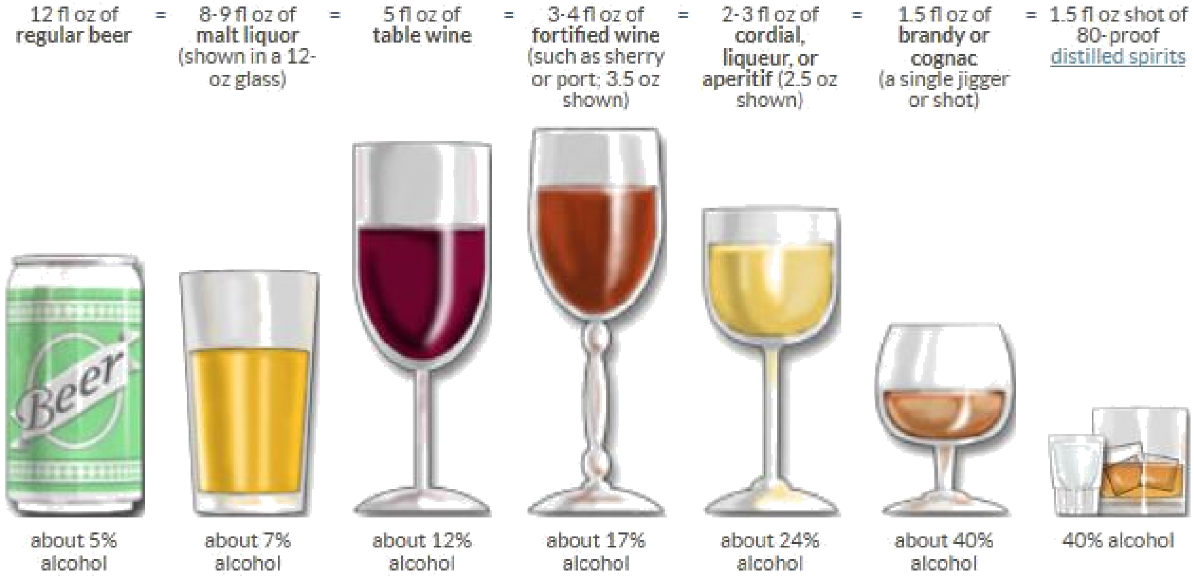
Please specify the average frequency of total alcohol use? Select one.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Don't know ◯ Prefer not to answer

What's a "standard" drink?

Although the drinks pictured here are different sizes, each contains approximately the same amount of alcohol and counts as one U.S. standard drink or one alcoholic drink-equivalent.

Bottle of Wine = 5 drinks

Bottle of Spirits = 17 drinks



Please specify the average quantity of total [pstfreq_drnk_yrs1] alcohol use

- ◯ 1
- ◯ 2
- ◯ 3
- ◯ 4
- ◯ 5
- ◯ 6
- ◯ 7
- ◯ 8
- ◯ 9
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◯ 96
◯ 97
◯ 98
◯ 99
◯ 100
◯ Don't know
◯ Prefer not to answer
(drinks)

How many total years have you drank alcohol? ________________________________

How many years has it been since you stopped drinking alcohol? ________________________________

Any additional information not captured above in regards to alcohol use ____

Are you currently using or have you ever used any of the following substances? Select all that apply.

	Daily	Weekly	Monthly	Yearly	Less than once a year	No current use (past 3 months), but has used and quit in the past	No current use, but tried once in the past	Never - no current or past use	Don't know	Prefer not to answer
Tobacco (ALTERNATE forms other than smoking cigarettes)										
CBD (oils, edible, topical)										
Cannabis (THC, marijuana, joints, edibles)										
Heroin (dust, horse, junk, down, or downtown)										
Heroin + Cocaine (speedballs)										
Cocaine alone (uptown, up)										
Crack (rock, freebase cocaine)										
Methamphetamine (crystal meth, ice, jib, gak)										
Benzodiazepine										
Dilaudid (hydromorphone hydrochloride)										
OxyContin/OxyCodone/OxyNeo										
Morphine (Kadian, MS Contin, M-Eslon)										
Methadone (Methadose, Metadol)										
Talwin & Ritalin (T&Rs)										
Tylenol 3, Tylenol 4 (T3s, T4s, Emtec) (codeine) or any over-the-counter drug containing codeine not as prescribed.										
Ecstasy equivalent (x-tasy, E.X)										
Gabapentin										
MDA (Sassafras, Sally)										
Speed (amphetamines, uppers)										

Acid (LSD, PCP, angel dust)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Mushrooms (magic mushrooms, mush)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Ketamine (special K)	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Sleeping pills	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Fentanyl or Carfentanil	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
Other	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

The next section will ask about current frequency or past duration of use for each individual substance indicated above. We are looking for numbers that represent your best estimate.

Please specify the frequency of your past tobacco use (alternate forms other than smoking cigarettes).

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using tobacco (alternate forms other than smoking cigarettes)?

____

How many total years have you used tobacco (alternate forms other than smoking cigarettes)?

____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past CBD use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using CBD?

____

How many total years have you used CBD?

____
(This does not include years where you stopped or quit.)

Please specify the frequency of your past cannabis (marijuana, THC) use.

◯ Daily
◯ Weekly
◯ Monthly
◯ Yearly
◯ Less than once a year
◯ Don't know
◯ Prefer not to answer

How many years has it been since you stopped using cannabis (marijuana, THC)?

____

How many total years have you used cannabis (marijuana, THC)?	__________________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past heroin use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using heroin?	__________________________________
How many total years have you used heroin?	__________________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past heroin + cocaine (speedballs) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using heroin + cocaine (speedballs)?	__________________________________
How many total years have you used heroin + cocaine (speedballs)?	__________________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past cocaine use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using cocaine?	__________________________________
How many total years have you used cocaine?	__________________________________ (This does not include years where you stopped or quit.)

Please specify the frequency of your past crack use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using crack?	__________________________
How many total years have you used crack?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past methamphetamine (crystal meth, ice, jib, gak) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using methamphetamine (crystal meth, ice, jib, gak)?	__________________________
How many total years have you used methamphetamine (crystal meth, ice, jib, gak)?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past benzodiazepine use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using benzodiazepine?	__________________________
How many total years have you used benzodiazepine?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past dilaudid (hydromorphone hydrochloride) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using dilaudid (hydromorphone, hydrochloride)?	__________________________

How many total years have you used dilaudid (hydromorphone hydrochloride)?	______________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past OxyContin/OxyCodone/OxyNeo use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using OxyContin/OxyCodone/OxyNeo?	______________________
How many total years have you used OxyContin/OxyCodone/OxyNeo?	______________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past morphine use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using morphine?	______________________
How many total years have you used morphine?	______________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past methadone (methadose, metadol) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using methadone (methadose, metadol)?	______________________
How many total years have you used methadone (methadose, metadol)?	______________________ (This does not include years where you stopped or quit.)

Please specify the frequency of your past talwin & ritalin (T&Rs) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using talwin & ritalin (T&Rs)?	________________________
How many total years have you used talwin & ritalin (T&Rs)?	________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past use of T3s T4s (codeine) or any over-the-counter drug containing codeine not as prescribed.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using T3s T4s (codeine) or any over-the-counter drug containing codeine not as prescribed?	________________________
How many total years have you used T3s T4s (codeine) or any over-the-counter drug containing codeine not as prescribed?	________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past ecstasy equivalent (x-tasy, E.X) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using ecstasy equivalent (x-tasy, E.X)?	________________________
How many total years have you used ecstasy equivalent (x-tasy, E.X)?	________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past gabapentin use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using gabapentin?	________________________

How many total years have you used gabapentin?	__________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past MDA (Sassafras, Sally) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using MDA (Sassafras, Sally)?	__________________
How many total years have you used MDA (Sassafras, Sally)?	__________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past speed (amphetamines, uppers) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using speed (amphetamines, uppers)?	__________________
How many total years have you used speed (amphetamines, uppers)?	__________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past acid (LSD, PCP, angel dust) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using acid (LSD, PCP, angel dust)?	__________________
How many total years have you used acid (LSD, PCP, angel dust)?	__________________ (This does not include years where you stopped or quit.)

Please specify the frequency of your past mushrooms (magic mushrooms, mush) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using mushrooms (magic mushrooms, mush)?	__________________________
How many total years have you used mushrooms (magic mushrooms, mush)?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past ketamine (special K) use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using ketamine (special K)?	__________________________
How many total years have you used ketamine (special K)?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past sleeping pills use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using sleeping pills?	__________________________
How many total years have you used sleeping pills?	__________________________ (This does not include years where you stopped or quit.)
Please specify the frequency of your past fentanyl or carfentanil use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using fentanyl or carfentanil?	__________________________

How many total years have you used fentanyl or carfentanil?	__________________________________ (This does not include years where you stopped or quit.)
Please specify the "other" drug, you indicated you use	__________________________________
Please specify the frequency of your past [substothspec] use.	◯ Daily ◯ Weekly ◯ Monthly ◯ Yearly ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
How many years has it been since you stopped using [substothspec]?	__________________________________
How many total years have you used [substothspec]?	__________________________________ (This does not include years where you stopped or quit.)
Do you vape (also known as smoking e-cigarettes)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
Please select the substance(s) in your e-liquid or e-juice.	☐ Nicotine ☐ THC ☐ CBD ☐ Other ☐ Don't know ☐ Prefer not to answer
Please specify "other"	__________________________________
How often do you use your e-cigarette / vape?	◯ Daily ◯ Weekly ◯ Monthly ◯ Less than once a month, but more than once a year ◯ Less than once a year ◯ Don't know ◯ Prefer not to answer
Have you ever experienced an overdose from use of substances? Select one.	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

How many overdoses have you experienced in the last 6 months? Indicate number:

○ 0
○ 1
○ 2
○ 3
○ 4
○ 5
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- ◯ 98
- ◯ 99
- ◯ 100
- ◯ Don't know
- ◯ Prefer not to answer

Any additional information not captured above about substance use?

____

REDOSE Stigma And Discrimination

Please complete the survey below.

Thank you!

This next section is about stigma and discrimination as it pertains to HIV. We include these questions because we understand that stigma and discrimination is a very apparent issue in the context of HIV. This subject may be very difficult to talk or hear about, and it may stir up uncomfortable feelings, or emotional distress. If it becomes challenging at any point, please skip these questions by selecting "don't know/prefer not to answer". You can also stop or take a break at any time if you still prefer to answer. We will be providing you with a copy of our resources with peer/community support at the end of the survey. Please know that your responses are completely confidential.

Is it okay if I continue guiding you through the questions in this section?

- ◯ I'd prefer to complete this section myself
- ◯ I'd prefer to complete this section together
- ◯ I'd prefer to skip this entire section

Would you like to proceed with the questions in this section?

- ◯ I'd prefer to complete this section
- ◯ I'd prefer to skip this entire section

For each of the following items, please indicate how often have people treated you this way in the past because of your HIV status. These questions can refer to your entire life.

The following questions are part of a validated HIV stigma scale.

Select one per line.

Because of your HIV status...

	Never	Not Often	Somewhat Often	Often	Very Often	N/A, i.e. have never disclosed	Don't know	Prefer not to answer
a. Family members have avoided me.	◯	◯	◯	◯	◯	◯	◯	◯
b. Family members have looked down on me.	◯	◯	◯	◯	◯	◯	◯	◯
c. Family members have treated me differently.	◯	◯	◯	◯	◯	◯	◯	◯
d. Community/social workers have not taken my needs seriously.	◯	◯	◯	◯	◯	◯	◯	◯
e. Community/social workers have discriminated against me.	◯	◯	◯	◯	◯	◯	◯	◯
f. Community/social workers have denied me services.	◯	◯	◯	◯	◯	◯	◯	◯

g. Healthcare workers have not listened to my concerns.	○	○	○	○	○	○	○	○
h. Healthcare workers have avoided touching me.	○	○	○	○	○	○	○	○
i. Healthcare workers have treated me with less respect.	○	○	○	○	○	○	○	○
j. I have been denied services due to my HIV status (e.g. travelling into another country, life/health insurance, job opportunities, housing, etc.)	○	○	○	○	○	○	○	○

How, if at all, have your experiences with external stigma and discrimination changed since you were first diagnosed with HIV? Select one.

- ○ My experiences with stigma and discrimination have significantly improved
- ○ My experiences with stigma and discrimination have improved slightly
- ○ My experiences have not changed since I was first diagnosed
- ○ My experiences with stigma and discrimination have worsened slightly
- ○ My experiences with stigma and discrimination have significantly worsened
- ○ Don't know
- ○ Prefer not to answer

For the following questions please say if you strongly agree, agree, neither agree or disagree, disagree, or strongly disagree with the following statements:

Select one per row.

In the past month, would you say...

	Strongly Agree	Agree	Neither agree or disagree	Disagree	Strongly Disagree	Don't know	Prefer not to answer
a. I've limited what I tell others about myself	○	○	○	○	○	○	○
b. I've been afraid to tell other people that I have HIV	○	○	○	○	○	○	○
c. I've been worried about my family members finding out that I have HIV	○	○	○	○	○	○	○
d. I've been worried about people at my job/routine daily activities finding out that I have HIV	○	○	○	○	○	○	○

e. I've been worried that I'll lose my source of income if other people find out that I have HIV	○	○	○	○	○	○	○
f. I've been worried that I'll lose access to health services or care if people find out that I have HIV	○	○	○	○	○	○	○

How, if at all, have your experiences with internal stigma changed since you were first diagnosed with HIV?

- ○ My experiences with self-stigma have improved significantly
- ○ My experiences with self-stigma have improved slightly
- ○ My experiences have not changed since I was first diagnosed
- ○ My experiences with self-stigma have worsened slightly
- ○ My experiences with self-stigma have worsened significantly
- ○ Don't know
- ○ Prefer not to answer

For each of the following items, please indicate whether you: Strongly Agree, Agree, Neither Agree nor Disagree, Disagree, or Strongly Disagree.

These questions can refer to your entire life.

Select one per line.

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Don't know	Prefer not to answer
a. I have been hurt by how people reacted to learning I have HIV.	○	○	○	○	○	○	○
b. I have stopped socializing with some people because of their reactions of me having HIV.	○	○	○	○	○	○	○
c. I have lost friends by telling them I have HIV.	○	○	○	○	○	○	○
d. I am very careful who I tell that I have HIV.	○	○	○	○	○	○	○
e. I worry that people who know I have HIV will tell others.	○	○	○	○	○	○	○
f. I feel that I am not as good a person as others because I have HIV.	○	○	○	○	○	○	○

g. Having HIV makes me feel unclean.	○	○	○	○	○	○	○
h. Having HIV makes me feel that I'm a bad person.	○	○	○	○	○	○	○
i. Most people think that a person with HIV is disgusting.	○	○	○	○	○	○	○
j. Most people with HIV are rejected when others find out.	○	○	○	○	○	○	○

REDOSE Chronic Pain and Physical Wellbeing

Please complete the survey below.

Thank you!

The following section includes a series of questions about chronic pain as it relates to your overall health.

How much bodily pain have you had during the last week?

- ◯ none
- ◯ very mild
- ◯ mild
- ◯ moderate
- ◯ severe
- ◯ very severe

Do you have bodily pain that has lasted for more than 3 months?

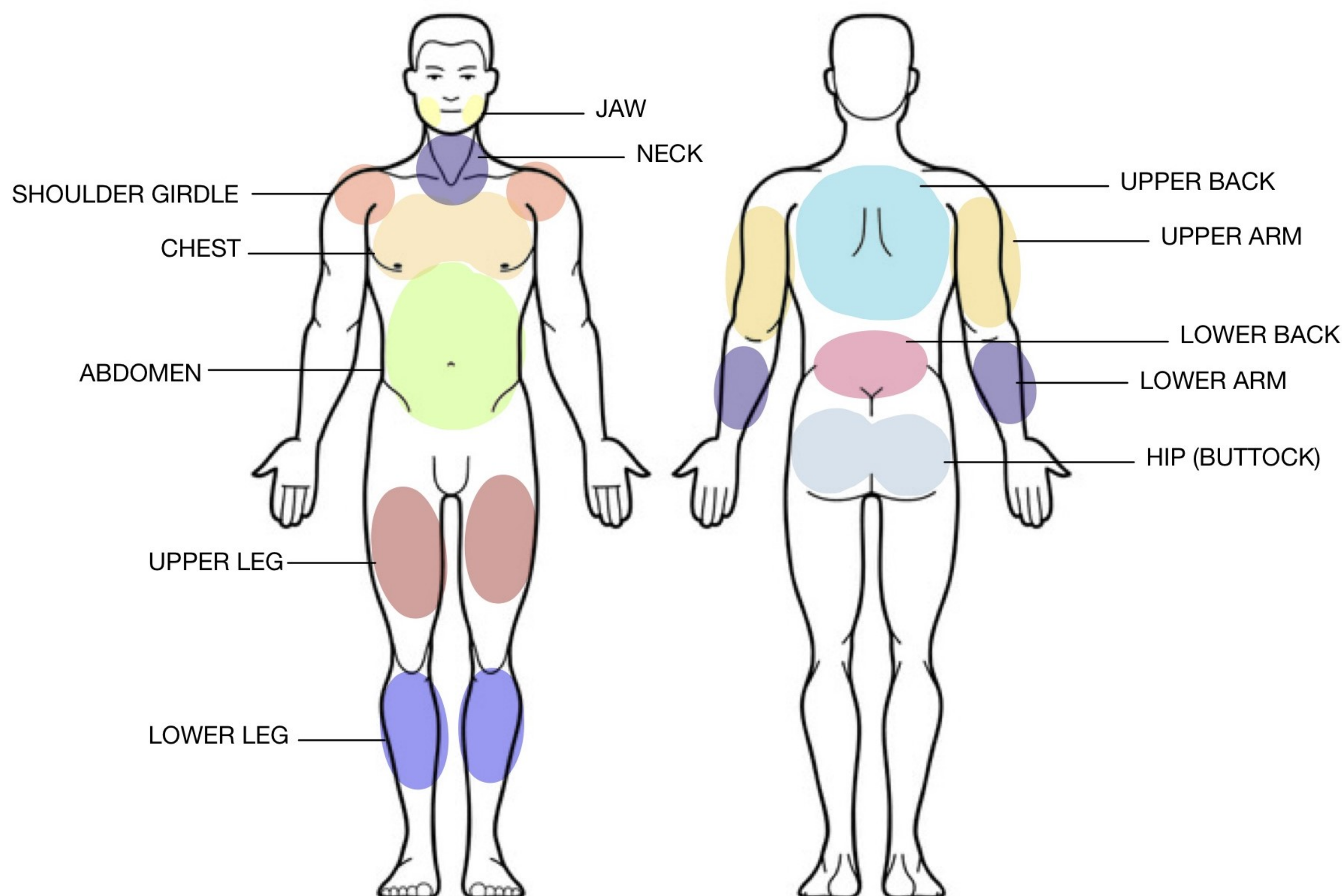
- ◯ Yes
- ◯ No

The following questions will ask you to rate your pain on a scale of one to ten with respect to how it interferes with your life.

0 indicates that pain does not interfere and 10 indicates that pain completely interferes.

	Does not interfere, 0	1	2	3	4	5	6	7	8	9	Completely interferes, 10
What number best describes your pain on average in the past week?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
What number best describes how, during the past week, pain has interfered with your enjoyment of life?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯
What number best describes how, during the past week, pain has interfered with your general activity?	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯	◯

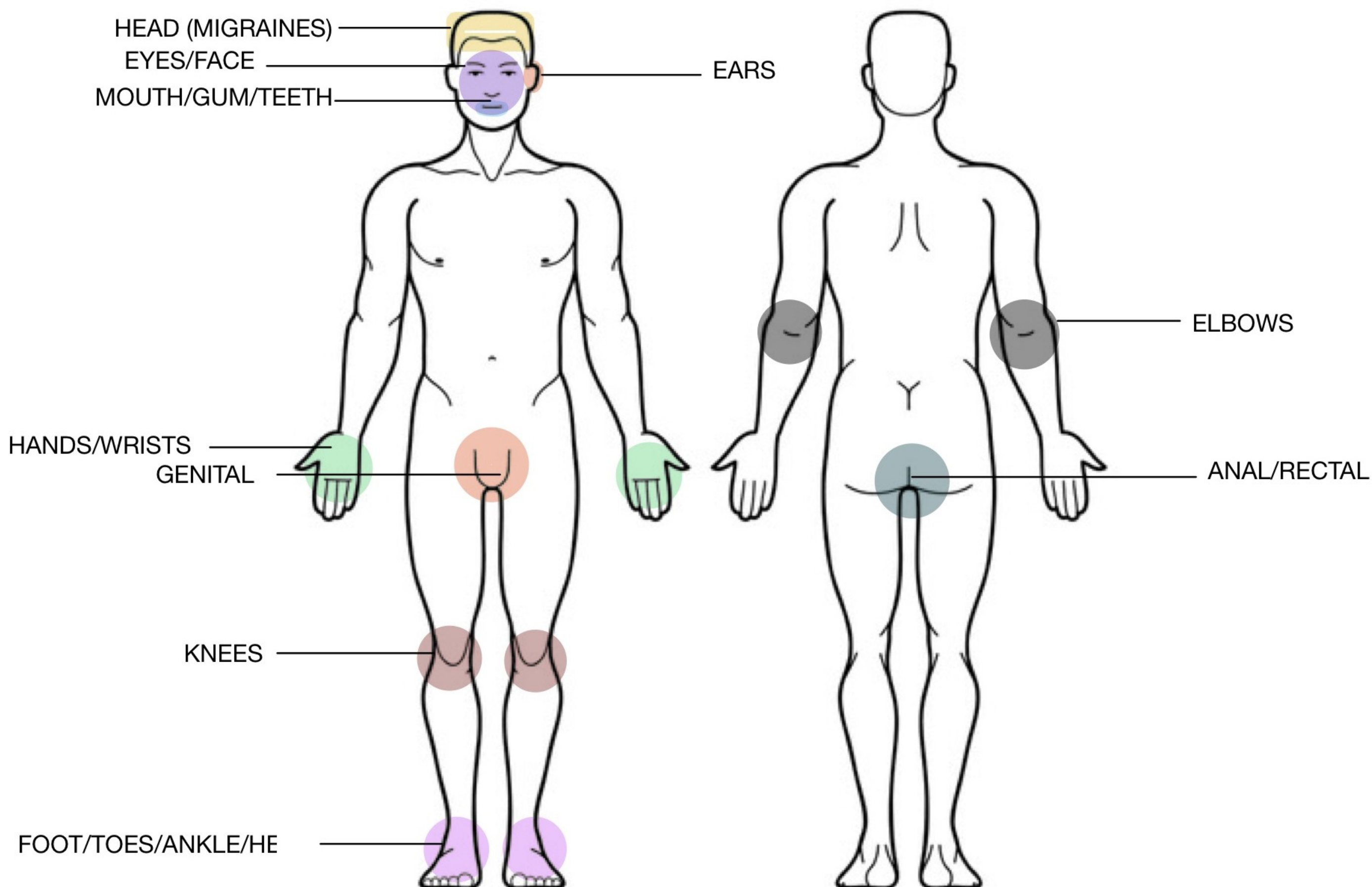
Please use this image to help localize your pain in the following question.



Please check each area you have felt pain in over the past week. This list may not cover your pain, so please select other and a second list will open.

- ☐ Shoulder girdle, left
- ☐ Shoulder girdle, right
- ☐ Upper arm, left
- ☐ Upper arm, right
- ☐ Lower arm, left
- ☐ Lower arm, right
- ☐ Hip (buttock) left
- ☐ Hip (buttock) right
- ☐ Upper leg left
- ☐ Upper leg right
- ☐ Lower leg left
- ☐ Lower leg right
- ☐ Jaw left
- ☐ Jaw right
- ☐ Chest
- ☐ Abdomen
- ☐ Neck
- ☐ Upper back
- ☐ Lower back
- ☐ Other/None of these areas, see next image

Please use this image to help localize your pain in the following question.



Additional areas of pain. Please check each area you have felt pain in over the past week

- ☐ Foot/ankle/heel left
- ☐ Foot/ankle/heel right
- ☐ Knee left
- ☐ Knee right
- ☐ Elbow left
- ☐ Elbow right
- ☐ Wrist left
- ☐ Wrist right
- ☐ Hand/fingers left
- ☐ Hand/fingers right
- ☐ Head (migraines)
- ☐ Eyes/face
- ☐ Mouth/gums/teeth
- ☐ Ear
- ☐ Genital
- ☐ Anal/rectal
- ☐ Other

Please specify "Other"

____

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer, select one of the options on the scale under each item, from "not at all confident" to "completely confident".

	Not at all confident, 0	1	2	3	4	5	Completely confident, 6
I can cope with my pain in most situations	◯	◯	◯	◯	◯	◯	◯
I can still do many of the things I enjoy doing, such as hobbies or leisure activity, despite pain.	◯	◯	◯	◯	◯	◯	◯
I can still accomplish most of my goals in life, despite the pain.	◯	◯	◯	◯	◯	◯	◯
I can live a normal lifestyle, despite the pain.	◯	◯	◯	◯	◯	◯	◯

Do you have to modify/adapt your hobbies or leisure activities due to your chronic pain?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you experience stigma, isolation, and/or discrimination due to your chronic pain?

- ◯ Extremely
- ◯ Quite a bit
- ◯ Moderately
- ◯ Very little/Occasionally
- ◯ Not at all
- ◯ Don't know
- ◯ Prefer not to answer

Do you ever use medications (prescribed or over the counter) to cope with your chronic pain?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Do you ever use substances (alcohol, marijuana, cigarettes, or other substances) to cope with your chronic pain?

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

If you experience any mental health diagnoses (ie. depression, anxiety, etc.), do you think they are related to your chronic pain?

- ◯ Yes
- ◯ Maybe
- ◯ No
- ◯ No, I do not have any mental health diagnoses
- ◯ Don't know
- ◯ Prefer not to answer

Does your chronic pain interfere with your quality of sleep? Please select all that apply.

- ☐ Yes, I have difficulty falling asleep
- ☐ Yes, I wake in the night
- ☐ Yes, I wake early
- ☐ No
- ☐ Don't know
- ☐ Prefer not to answer

Question	Response
Do you think that living with chronic pain has influenced your experience of ARV side effects?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How has chronic pain changed the way you experience ARV side effects? Select all that apply.	☐ Chronic pain has made my ARV side effects worse ☐ Chronic pain has made it easier for me to tolerate ARV side effects ☐ The treatments that I use to manage my ARV side effects are different because of my chronic pain ☐ Other: __________ ☐ Don't know ☐ Prefer not to answer
Please specify "Other"	__________________
How much do you agree or disagree with the following statement: "I feel resilient and strong because I cope with chronic pain."	◯ Strongly agree ◯ Agree ◯ Neither agree nor disagree ◯ Disagree ◯ Strongly disagree ◯ Don't know ◯ Prefer not to answer
I have support in place to help me navigate my chronic pain journey.	◯ Yes ◯ No ◯ No, and I would like some support ◯ Don't know ◯ Prefer not to answer

The following section includes a series of questions about your sleep health.

Question	Response
How satisfied or dissatisfied are you with your current sleep pattern? Select one.	◯ Very satisfied ◯ Satisfied ◯ Neutral ◯ Dissatisfied ◯ Very dissatisfied ◯ Don't know ◯ Prefer not to answer
During the past month, on average, how many hours of actual sleep did you get at night? (This may be different than the numbers of hours you spend in bed.)	__________________ (Enter 9999 if "Don't know" or 7777 if "Prefer not to answer")
In the past 3 months, have you noticed changes in your sleep? If yes, please indicate which of the following is MOST changed.	◯ No changes ◯ Yes, waking early ◯ Yes, mid-sleep awakening ◯ Yes, problems falling asleep ◯ Yes, getting more sleep
Has a doctor ever told you that you have a sleep disorder (i.e. sleep apnea, restless legs, insomnia)?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer

Do you take/use anything for sleep? Please select all that apply.

- ☐ NONE
- ☐ Melatonin
- ☐ Teas
- ☐ Cannabis
- ☐ Music
- ☐ Yoga
- ☐ Meditation
- ☐ Sleeping pills
- ☐ CPAP machine
- ☐ Other
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

____

The following section includes a series of questions intended to understand your testosterone health. If you feel uncomfortable answering any of the following questions, feel free to skip. Please know that your responses are completely confidential.

Please read the following statements and rate from 1 (Terrible) to 5 (Excellent) how each applies to you. The following questions are part of a validated scale.

	Terrible	Poor	Average	Good	Excellent	Don't know	Prefer not to answer
a. How would you rate your libido* (sex drive)? *Libido is a person's innate desire for sexual activity whether with a partner or alone, physically or in fantasies. An individual's libido can change depending on their hormone levels, personal circumstances, emotional well-being, and overall lifestyle.	○	○	○	○	○	○	○
b. How would you rate your energy level?	○	○	○	○	○	○	○
c. How would you rate your strength/endurance?	○	○	○	○	○	○	○
d. How would you rate your enjoyment of life?	○	○	○	○	○	○	○
e. How would you rate your happiness levels?	○	○	○	○	○	○	○
f. How would you rate your work performance over the past 4 weeks?	○	○	○	○	○	○	○

g. How would you rate your sports ability over the past 4 weeks?	◯	◯	◯	◯	◯	◯	◯

How strong are your erections?	◯ 1 = Extremely Weak ◯ 2 ◯ 3 ◯ 4 ◯ 5 = Extremely Strong
How often do you fall asleep after an evening meal?	◯ Never ◯ 1-2 times a week ◯ 3-4 times a week ◯ 5-6 times a week ◯ Every night
Have you noticed that you have lost height?	◯ Yes ◯ No ◯ Don't know ◯ Prefer not to answer
How much height have you lost?	◯ 2" or more ◯ 1.5" to 1.9" ◯ 1 to 1.4" ◯ 0.5 to 0.9" ◯ None to 0.4"

REDOSE Social Support

Please complete the survey below.

Thank you!

People sometimes look to others for companionship, assistance, or other types of support. How often is each of the following kinds of support available to you if you need it?

Select one response per line.

How often do you have available...

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Prefer not to answer
a. Someone to turn to for suggestions about how to deal with a personal problem.	◯	◯	◯	◯	◯	◯	◯
b. Someone to help with daily chores if you were sick.	◯	◯	◯	◯	◯	◯	◯
c. Someone to love and make you feel wanted.	◯	◯	◯	◯	◯	◯	◯
d. Someone to do something enjoyable with.	◯	◯	◯	◯	◯	◯	◯

Approximately how many men living with HIV do you know personally, including friends and colleagues? Please try to provide your best estimate. Select one.

- ◯ None
- ◯ 1 person
- ◯ 2 to 4 people
- ◯ 5 to 9 people
- ◯ 10 to 19 people
- ◯ 20 to 49 people
- ◯ 50 to 99 people
- ◯ 100 or more
- ◯ Don't know
- ◯ Prefer not to answer

In your life, do you have someone living with HIV who you get support from? For this question, please think about friends or family living with HIV who you can call on in times of need, rather than someone who you only know in a formal role, such as a peer navigator. This person can be a friend or a peer. Select one.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

How much do you agree or disagree with the following statement: "As a man living with HIV in my community, I feel isolated". Select one.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree or disagree
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Prefer not to answer

How much do you agree or disagree with the following statement: "I don't reach out to friends or stay in touch, because I can't explain my life living with HIV to them". Select one.

- ◯ Strongly agree
- ◯ Agree
- ◯ Neither agree or disagree
- ◯ Disagree
- ◯ Strongly disagree
- ◯ Prefer not to answer

REDOSE Emotional and Social Wellbeing and Health

Please complete the survey below.

Thank you!

The following section includes a series of questions about emotional wellbeing and quality of life as it relates to your overall mental and physical health.

Have you ever been diagnosed with a mental health condition by a care provider? Select one.

- ◯ Yes
- ◯ No
- ◯ Don't know
- ◯ Prefer not to answer

Which, if any, of the following mental health conditions are you currently living with? Please only include conditions that have been diagnosed by a healthcare provider. Select all that apply.

- ☐ Alcohol Addiction
- ☐ Anxiety
- ☐ Anorexia Nervosa or Bulimia Nervosa
- ☐ ADD/ADHD (i.e., Attention deficit (hyperactivity) disorder)
- ☐ Bipolar Disorder
- ☐ Personality Disorder
- ☐ Dementia
- ☐ Depression
- ☐ Drug Addiction/Substance Use Disorder
- ☐ Obsessive-Compulsive Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Schizophrenia
- ☐ Sleep disorder
- ☐ Other, please specify:
- ☐ None
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other" ______________________________

Below is a list of the ways you might have felt or behaved during the past week. Please tell me how often you have felt this way during the past week.

Select one per line.

	Most or all of the time (5-7 days)	Occasionally or a moderate amount of the time (3-4 days)	Some or a little of the time (1-2 days)	Rarely or none of the time (less than 1 day)	Don't know	Prefer not to answer
a. I was bothered by things that usually don't bother me.	◯	◯	◯	◯	◯	◯
b. I had trouble keeping my mind on what I was doing.	◯	◯	◯	◯	◯	◯
c. I felt depressed	◯	◯	◯	◯	◯	◯

d. I felt that everything I did was an effort.	○	○	○	○	○	○
e. I felt hopeful about the future.	○	○	○	○	○	○
f. I felt fearful.	○	○	○	○	○	○
g. My sleep was restless.	○	○	○	○	○	○
h. I was happy.	○	○	○	○	○	○
i. I felt lonely.	○	○	○	○	○	○
j. I could not get "going".	○	○	○	○	○	○

During the past 30 days, about how often did you feel...

Select one per line.

	All of the time	Most of the time	Some of the time	A little of the time	None of the time	Don't know	Prefer not to answer
a. Nervous?	○	○	○	○	○	○	○
b. Hopeless?	○	○	○	○	○	○	○
c. Restless or fidgety?	○	○	○	○	○	○	○
d. That everything was an effort?	○	○	○	○	○	○	○
e. So depressed that nothing could cheer you up?	○	○	○	○	○	○	○
f. Worthless?	○	○	○	○	○	○	○

Over the last 2 weeks, how often have you been bothered by the following problems?

	Not at all	Several days	Over half the days	Nearly every day
a. Feeling nervous, anxious, or on edge	○	○	○	○
b. Not being able to stop or control worrying	○	○	○	○
c. Worrying too much about different things	○	○	○	○
d. Trouble relaxing	○	○	○	○
e. Being so restless that it's hard to sit still	○	○	○	○
f. Becoming easily annoyed or irritable	○	○	○	○
g. Feeling afraid as if something awful might happen	○	○	○	○

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? Please select one.

- ○ Not difficult at all
- ○ Somewhat difficult
- ○ Very difficult
- ○ Extremely difficult

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

Select one per line.

	Yes limited a lot	Yes limited a little	No, not limited at all	Prefer not to answer
a. Moderate activities such as moving a table, pushing a vacuum cleaner, bowling, or playing golf.	○	○	○	○
b. 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?

Select one per line.

	Yes	No	Prefer not to answer
a. Accomplished less than you would like	○	○	○
b. Were limited in the kind of work or other activities	○	○	○

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)?

Select one per line.

	Yes	No	Don't know	Prefer not to answer
a. Accomplished less than you would like	○	○	○	○
b. Didn't do work or other activities as carefully as usual	○	○	○	○

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

- ○ Extremely
- ○ Quite a bit
- ○ Moderately
- ○ A little bit
- ○ Not at all
- ○ Prefer not to answer

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.

How much of the time during the past 4 weeks...

Select one per line.

	All of the time	Most of the time	Some of the time	A little of the some	None of the time	Don't know	Prefer not to answer
a. Have you felt calm and peaceful?	◯	◯	◯	◯	◯	◯	◯
b. Did you have a lot of energy?	◯	◯	◯	◯	◯	◯	◯
c. Have you felt downhearted and blue?	◯	◯	◯	◯	◯	◯	◯

During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)? Select one.

- ◯ All of the time
- ◯ Most of the time
- ◯ Some of the time
- ◯ A little of the time
- ◯ None of the time
- ◯ Don't know
- ◯ Prefer not to answer

In general, would you say your health is: Select one.

- ◯ Excellent
- ◯ Very Good
- ◯ Good
- ◯ Fair
- ◯ Poor
- ◯ Prefer not to answer

Compared to one year ago, how would you rate your health in general now?

- ◯ Much better now than one year ago
- ◯ Somewhat better now than one year ago
- ◯ About the same as one year ago
- ◯ Somewhat worse now than one year ago
- ◯ Much worse now than one year ago

For mental health and wellbeing purposes, do you seek out or use any of the following? Select all that apply.

- ☐ Counselling
- ☐ Peer support
- ☐ Support from a spiritual healer
- ☐ Support from a spiritual leader (ie. priest, church member, etc.)
- ☐ Support from an Elder(s) (Indigenous community leader)
- ☐ Traditional methods of healing (ie. smudge, sweat lodge, dancing, praying, etc.)
- ☐ Other, specify
- ☐ None of the above
- ☐ Don't know
- ☐ Prefer not to answer

Please specify "Other"

____

REDOSE Resilience

Please complete the survey below.

Thank you!

This is the final section of the survey, it contains some important questions about resiliency*. Please go through the questions carefully. There will then be an opportunity to offer any feedback or comments on the survey.

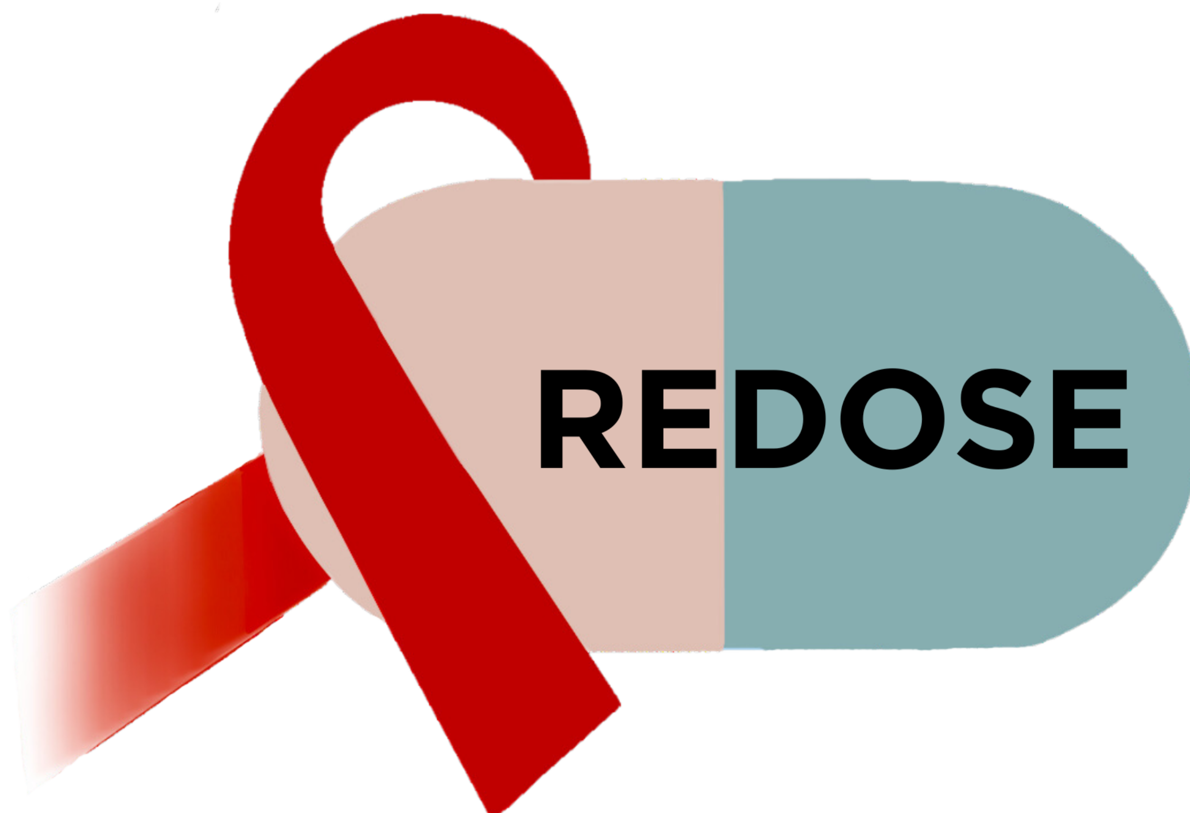
*Resilience is the inner strength that helps individuals bounce back and carry on in the face of adversity.

Please read the following statements regarding resiliency*. To the right of each, you will find seven options, ranging from Strongly Agree on the left to Strongly Disagree on the right. Please select the option which best indicates your feelings about that statement. Select one per line.
***Resilience is the inner strength that helps individuals bounce back and carry on in the face of adversity.**
The following questions are part of a validated scale.

	Strongly Agree	Moderately Agree	Slightly Agree	Neither Agree or Disagree	Slightly Disagree	Moderately Disagree	Strongly Disagree	Prefer not to answer
a. I usually manage one way or another	○	○	○	○	○	○	○	○
b. I feel proud that I have accomplished things in life	○	○	○	○	○	○	○	○
c. I usually take things in stride	○	○	○	○	○	○	○	○
d. I am friends with myself	○	○	○	○	○	○	○	○
e. I feel that I can handle many things at a time	○	○	○	○	○	○	○	○
f. I am determined	○	○	○	○	○	○	○	○
g. I can get through difficult times because I've experienced difficulty before	○	○	○	○	○	○	○	○
h. I have self-discipline	○	○	○	○	○	○	○	○
i. I keep interested in things	○	○	○	○	○	○	○	○
j. I can usually find something to laugh about	○	○	○	○	○	○	○	○
k. My belief in myself gets me through hard times	○	○	○	○	○	○	○	○
l. In an emergency, I'm someone people can generally rely on	○	○	○	○	○	○	○	○
m. My life has meaning	○	○	○	○	○	○	○	○
n. When I'm in a difficult situation, I can usually find my way out of it	○	○	○	○	○	○	○	○

You have completed the survey. Thank you for participating in the REDOSE study! Thank you for taking the time to complete the survey. If you have any final comments, please indicate them here.	__________________________________
How did you find out about the study?	☐ Oak Tree Clinic ☐ St. Paul's Hospital ☐ Positive Health Clinic ☐ HIM Clinic ☐ Poster ☐ Social media post ☐ Through healthcare provider ☐ Through a friend ☐ Email list ☐ Other, please specify:
Please specify "Other":	____________________________
Sometimes participating in research leaves study participants with questions. Would you like a Research Assistant to follow up with you to discuss any questions you might have about the study?	◯ Yes ◯ No

Thank you for participating in our study!



REDOSE Visit Anthropometrics

Is this participant a patient at OTC or SPH?	◯ Oak Tree Clinic ◯ St. Paul's Hospital ◯ N/A; the participant is not a patient of either clinic
Consented for additional tests on samples?	◯ Yes ◯ No
Consented to biobanking?	◯ Yes ◯ No
Height	______________________ (unit: cm, enter 9999 if unknown or not done)
Weight	______________________ (unit: kg, enter 9999 if unknown or not done)
Systolic blood pressure	______________________ (enter 9999 if unknown or not done)
Diastolic Blood Pressure	______________________ (enter 9999 if unknown or not done)
NIH waist circumference measurement (top of hip bone/iliac crest)	______________________ (enter 9999 if unknown or not done)
WHO waist circumference measurement (midpoint between bottom rib and hip bone)	______________________ (enter 9999 if unknown or not done)
Was a urine sample collected (albumin creat ratio)?	◯ Yes ◯ No
Date of urine sample collection	______________________
Was a mouth swab collected?	◯ Yes, 2 swabs ◯ Yes only 1 swab ◯ No
Date of mouth swab collection	______________________
Was a rectal swab collected?	◯ Yes, 2 swabs ◯ Yes only 1 swab ◯ No
Date of rectal swab collection	______________________

At what time and date did you last take your ARVs (HIV medications)?	__________________________________
ARVs taken	__________________________________ (Enter 7777 if prefer not to answer or 9999 if don't know)
Was a blood sample collected?	◯ Yes ◯ No
Time of blood draw	__________________________________
BMI	__________________________________
Was the first 4-meter walk test attempted?	◯ Yes ◯ No
Does the participant regularly use any of the following when walking? Select all that apply.	☐ None ☐ A cane or walking stick ☐ A walker ☐ A wheelchair ☐ A scooter ☐ Other, please specify
Please specify "Other"	__________________________________
Why was the first 4-meter walk not attempted?	☐ Participant refused ☐ Physically unable to complete ☐ Other, please specify: __________
Please specify "Other"	__________________________________
What was the result of the first walk test? Please record up to 2 decimal points.	__________________________________ (unit: seconds)
Was an assistive device used for the first walk test?	◯ Yes ◯ No
Was the second 4-meter walk test attempted?	◯ Yes ◯ No
Why was the second 4-meter walk not attempted?	☐ Participant refused ☐ Physically unable to complete ☐ Other, please specify: __________
Please specify "Other"	__________________________________

What was the result of the second walk test? Please record up to 2 decimal points.	________________ (unit: seconds)
Was an assistive device used for the second walk test?	◯ Yes ◯ No
Was the grip strength test attempted?	◯ Yes ◯ No
What is the participant's dominant hand?	◯ Left ◯ Right
Why was the grip strength test not attempted?	☐ Participant refused ☐ Physically unable to complete ☐ Other, please specify: __________
Please specify "Other"	________________
Was the grip strength test completed (all 3 tests done)?	◯ Yes ◯ No
Why was the grip strength test not completed?	☐ Participant refused ☐ Physically unable to complete ☐ Other, please specify: __________
Please specify "Other"	________________
What are the results for the grip strength test? Please write up to do 1 decimal point. Attempt #1 (kg) ______ ______ Attempt #2 (kg) ______ ______ Attempt #3 (kg) ______ ______	
Additional sample comments	________________

Lab Results

Date of first sample collection

____

Which of the following were collected?

- ☐ All Standard Tests
- ☐ White blood cell (wbc)
- ☐ Red blood cell count (RBC)
- ☐ Hemoglobin (hgb)
- ☐ Hematocrit
- ☐ Mean corpuscular volume (mcv)
- ☐ MCH
- ☐ RDW
- ☐ Platelet count
- ☐ MPV
- ☐ Neutrophils
- ☐ Lymphocytes
- ☐ Monocytes
- ☐ Eosinophils
- ☐ Basophils
- ☐ Calcium
- ☐ Creatinine (from blood sample)
- ☐ Estimated GFR
- ☐ Cholesterol
- ☐ Triglycerides
- ☐ HDL Calculated
- ☐ LDL Cholesterol
- ☐ Non-HDL
- ☐ Phosphate
- ☐ Total CO2
- ☐ Alkaline Phosphatase
- ☐ ALT
- ☐ AST
- ☐ Albumin
- ☐ HbA1C
- ☐ Random Blood Glucose
- ☐ Microalbumin Random Urine
- ☐ Creatinine Random Urine
- ☐ Microalbumin Creat Urine ratio

White blood cell (wbc)

____
(unit: x10^9/L)

Red blood cell count (RBC)

____
(unit: x10^12/L)

Hemoglobin

____
(unit: g/L)

Hematocrit

____

Mean corpuscular volume (mcv)

____
(unit: fL)

MCH

____
(unit: pg)

RDW

____
(unit: %)

Platelet count

____
(unit: x10^9/L)

MPV

____
(units: fL)

Neutrophils

____
(units: x10^9/L)

Lymphocytes

____
(units: x10^9/L)

Monocytes

____
(unit: x10^9/L)

Eosinophils

____
(unit: x10^9/L)

Basophils

____
(unit: x10^9/L)

Calcium

____
(unit: mmol/L)

Creatinine (from blood sample)

____
(unit: umol/L)

Estimated GFR

____
(unit: mL/min)

Cholesterol

____
(unit: mmol/L)

Triglycerides

____
(unit: mmol/L)

HDL Cholesterol

____
(unit: mmol/L)

LDL Cholesterol

____
(unit: mmol/L)

Non-HDL

____
(unit: mmol/L)

Phosphate

____
(unit: mmol/L)

Bicarbonate (Total CO2)

____
(unit: mmol/L)

Alkaline Phosphatase

____
(unit: U/L)

ALT

____
(unit: U/L)

AST

____
(unit: U/L)

Albumin

____
(unit: g/L)

HbA1C

____
(unit: %)

Random Blood Glucose

____
(unit: mmol/L)

Microalbumin Random Urine

____
(units: mg/L)

Creatinine Random Urine

____
(units: mmol/L)

Microalbumin Creat Urine ratio

____
(unit: mg/mmol Creat)

Was there a second sample collection?	◯ Yes ◯ No
Date of second sample collection	__________________________
Which of the following were collected?	☐ All Standard Tests ☐ White blood cell (wbc) ☐ Red blood cell count (RBC) ☐ Hemoglobin (hgb) ☐ Hematocrit ☐ Mean corpuscular volume (mcv) ☐ MCH ☐ RDW ☐ Platelet count ☐ MPV ☐ Neutrophils ☐ Lymphocytes ☐ Monocytes ☐ Eosinophils ☐ Basophils ☐ Calcium ☐ Creatinine (from blood sample) ☐ Estimated GFR ☐ Cholesterol ☐ Triglycerides ☐ HDL Calculated ☐ LDL Cholesterol ☐ Non-HDL ☐ Phosphate ☐ Total CO2 ☐ Alkaline Phosphatase ☐ ALT ☐ AST ☐ Albumin ☐ HbA1C ☐ Random Blood Glucose ☐ Microalbumin Random Urine ☐ Creatinine Random Urine ☐ Microalbumin Creat Urine ratio
White blood cell (wbc)	__________________________ (unit: x10^9/L)
Red blood cell count (RBC)	__________________________ (unit: x10^12/L)
Hemoglobin	__________________________ (unit: g/L)
Hematocrit	__________________________
Mean corpuscular volume (mcv)	__________________________ (unit: fL)

MCH

____
(unit: pg)

RDW

____
(unit: %)

Platelet count

____
(unit: x10^9/L)

MPV

____
(units: fL)

Neutrophils

____
(units: x10^9/L)

Lymphocytes

____
(units: x10^9/L)

Monocytes

____
(unit: x10^9/L)

Eosinophils

____
(unit: x10^9/L)

Basophils

____
(unit: x10^9/L)

Calcium

____
(unit: mmol/L)

Creatinine (from blood sample)

____
(unit: umol/L)

Estimated GFR

____
(unit: mL/min)

Cholesterol

____
(unit: mmol/L)

Triglycerides

____
(unit: mmol/L)

HDL Cholesterol

____
(unit: mmol/L)

LDL Cholesterol

____
(unit: mmol/L)

Non-HDL

____
(unit: mmol/L)

Phosphate

____
(unit: mmol/L)

Bicarbonate (Total CO2)

____
(unit: mmol/L)

Alkaline Phosphatase

____
(unit: U/L)

ALT

____
(unit: U/L)

AST

____
(unit: U/L)

Albumin

____
(unit: g/L)

HbA1C

____
(unit: %)

Random Blood Glucose

____
(unit: mmol/L)

Microalbumin Random Urine

____
(units: mg/L)

Creatinine Random Urine

____
(units: mmol/L)

Microalbumin Creat Urine ratio

____
(unit: mg/mmol Creat)

Was there a third sample collection?	◯ Yes ◯ No
Date of third sample collection	______________________________
Which of the following were collected?	☐ All Standard Tests ☐ White blood cell (wbc) ☐ Red blood cell count (RBC) ☐ Hemoglobin (hgb) ☐ Hematocrit ☐ Mean corpuscular volume (mcv) ☐ MCH ☐ RDW ☐ Platelet count ☐ MPV ☐ Neutrophils ☐ Lymphocytes ☐ Monocytes ☐ Eosinophils ☐ Basophils ☐ Calcium ☐ Creatinine (from blood sample) ☐ Estimated GFR ☐ Cholesterol ☐ Triglycerides ☐ HDL Calculated ☐ LDL Cholesterol ☐ Non-HDL ☐ Phosphate ☐ Total CO2 ☐ Alkaline Phosphatase ☐ ALT ☐ AST ☐ Albumin ☐ HbA1C ☐ Random Blood Glucose ☐ Microalbumin Random Urine ☐ Creatinine Random Urine ☐ Microalbumin Creat Urine ratio
White blood cell (wbc)	______________________________ (unit: x10^9/L)
Red blood cell count (RBC)	______________________________ (unit: x10^12/L)
Hemoglobin	______________________________ (unit: g/L)
Hematocrit	______________________________
Mean corpuscular volume (mcv)	______________________________ (unit: fL)

MCH

____
(unit: pg)

RDW

____
(unit: %)

Platelet count

____
(unit: x10^9/L)

MPV

____
(units: fL)

Neutrophils

____
(units: x10^9/L)

Lymphocytes

____
(units: x10^9/L)

Monocytes

____
(unit: x10^9/L)

Eosinophils

____
(unit: x10^9/L)

Basophils

____
(unit: x10^9/L)

Calcium

____
(unit: mmol/L)

Creatinine (from blood sample)

____
(unit: umol/L)

Estimated GFR

____
(unit: mL/min)

Cholesterol

____
(unit: mmol/L)

Triglycerides

____
(unit: mmol/L)

HDL Cholesterol

____
(unit: mmol/L)

LDL Cholesterol

____
(unit: mmol/L)

Non-HDL

____
(unit: mmol/L)

Phosphate

____
(unit: mmol/L)

Bicarbonate (Total CO2)

____
(unit: mmol/L)

Alkaline Phosphatase

____
(unit: U/L)

ALT

____
(unit: U/L)

AST

____
(unit: U/L)

Albumin

____
(unit: g/L)

HbA1C

____
(unit: %)

Random Blood Glucose

____
(unit: mmol/L)

Microalbumin Random Urine

____
(units: mg/L)

Creatinine Random Urine

____
(units: mmol/L)

Microalbumin Creat Urine ratio

____
(unit: mg/mmol Creat)

Notes

HIV History & Lab Results

Most Recent CD4 count (most recent from the visit date)	__________________________________
Date of most recent CD4 count (most recent from the visit date)	__________________________________
Lowest CD4 (nadir) count	__________________________________
Date of lowest CD4 (nadir) count	__________________________________
Most recent viral load (most recent from the visit date)	__________________________________
Date of the most recent viral load (most recent from the visit date)	__________________________________
Have they ever had a viral load over 100,000 copies?	◯ Yes ◯ No
Most recent CD4 count (from the self-reported date of the CD4 count they remember)	__________________________________
Date of most recent CD4 count (for the self-report project)	__________________________________
Most recent VL (for the self-report project)	__________________________________
Date of most recent VL (for the self-report)	__________________________________

Medication Chart Reviews

What were the encounter type(s) for this data?
- ☐ Physician/Nurse Note
- ☐ Pharmacy Note
- ☐ Medication List
- ☐ Not an OTC/SPH patient (No chart found)

Physician/Nurse Note Date ________________________

Pharmacy Note Date ________________________

Medication List Date ________________________

Antiretroviral Medications

Was the patient on an ARV regimen at their study visit?
- ◯ Yes
- ◯ No

What was the ARV regimen?

- ☐ 3TC (lamivudine)
- ☐ Atripla (efavirenz + FTC + tenofovir)
- ☐ Biktarvy (bictegravir + TAF + FTC)
- ☐ Cabenuva (injectable cabotegravir + rilpivirine)
- ☐ Celsentri (Maraviroc)
- ☐ Combivir (3TC + AZT)
- ☐ Complera (FTC + Tenofovir + Rilpivirine)
- ☐ Delstrigo (doravirine + 3TC + tenofovir)
- ☐ Descovy (FTC + TAF)
- ☐ Dovato (dolutegravir + lamivudine)
- ☐ Edurant (rilpivirine)
- ☐ Fuzeon (enfuvirtide, T-20)
- ☐ Genvoya (elvitegravir + cobicistat + TAF + FTC)
- ☐ Intelence (etravirine)
- ☐ Isentress (Raltegravir)
- ☐ Juluca (dolutegravir + rilpivirine)
- ☐ Kaletra (lopinavir + ritonavir)
- ☐ Kivexa (abacavir + lamivudine)
- ☐ Norvir (ritonavir)
- ☐ Odefsey (TAF + FTC + rilpivirine)
- ☐ Pifeltro (doravirine)
- ☐ Prezcobix (darunavir + cobicistat)
- ☐ Prezista (darunavir)
- ☐ Retrovir (AZT, zidovudine)
- ☐ Reyataz (atazanavir)
- ☐ Rukobia (Fostemsavir)
- ☐ Stribild (elvitegravir + cobicistat + TDF + FTC)
- ☐ Sunlenca (lenacapavir)
- ☐ Sustiva (efavirenz)
- ☐ Tivicay (Dolutegravir)
- ☐ Trizivir (ABC + 3TC + AZT)
- ☐ Triumeq (dolutegravir + 3TC + abacavir)
- ☐ Truvada (FTC + tenofovir)
- ☐ Viramune (nevirapine)
- ☐ Viread (tenofovir)
- ☐ Ziagen (abacavir)

3TC (lamivudine) dosage

____
(unit: mg, mcg, IU, mL, tab)

Atripla dosage

____
(unit: mg, mcg, IU, mL, tab)

Biktarvy dosage

____
(unit: mg, mcg, IU, mL, tab)

Cabenuva dosage interval

____
(unit: mg, mcg, IU, mL, tab)

Celsentri (maraviroc) dosage

____
(unit: mg, mcg, IU, mL, tab)

Combivir dosage

____
(unit: mg, mcg, IU, mL, tab)

Complera dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Delstrigo dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Descovy dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Dovato dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Edurant dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Fuzeon (enfuvirtide, T-20) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Genvoya dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Intelence (etravirine) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Isentress (Raltegravir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Juluca dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Kaletra dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Kivexa dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Norvir (ritonavir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Odefsey dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Pifeltro dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Prezcobix dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Prezista (darunavir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Retrovir (AZT, zidovudine) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Reyataz (atazanavir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Rukobia (Fostemsavir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Stribild dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Sunleca dosing interval

______________________ (unit: mg, mcg, IU, mL, tab)

Sustiva (efavirenz) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Tivicay (dolutegravir) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Trizivir dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Triumeq dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Truvada dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Viramune (nevirapine) dosage

______________________ (unit: mg, mcg, IU, mL, tab)

Viread (tenofovir) dosage

____
(unit: mg, mcg, IU, mL, tab)

Ziagen (abacavir) dosage

____
(unit: mg, mcg, IU, mL, tab)

Non-HIV Medications

Was the participant on non-HIV medications at the time of the study visit?

○ Yes
○ No

What was the medication?

____

[nhiv_rev1] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?

○ Yes
○ No

What was the medication?

____

[nhiv_rev2] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?

○ Yes
○ No

What was the medication?

____

[nhiv_rev3] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?

○ Yes
○ No

What was the medication?

____

[nhiv_rev4] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?

○ Yes
○ No

What was the medication?

____

[nhiv_rev5] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No
What was the medication?	______________
[nhiv_rev6] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No
What was the medication?	______________
[nhiv_rev7] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No
What was the medication?	______________
[nhiv_rev8] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No
What was the medication?	______________
[nhiv_rev9] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No
What was the medication?	______________
[nhiv_rev10] dosage	______________ (unit: mg, mcg, IU, mL, tab)
Are they taking any other non-HIV medications?	◯ Yes ◯ No

What was the medication?

____

[nhiv_rev11] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?
◯ Yes
◯ No

What was the medication?

____

[nhiv_rev12] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?
◯ Yes
◯ No

What was the medication?

____

[nhiv_rev13] dosage

____
(unit: mg, mcg, IU, mL, tab)

Are they taking any other non-HIV medications?
◯ Yes
◯ No

What was the medication?

____

[nhiv_rev14] dosage

____
(unit: mg, mcg, IU, mL, tab)

Please write down any other non-HIV medications the participant is taking or has taken in the last 3 months.

____