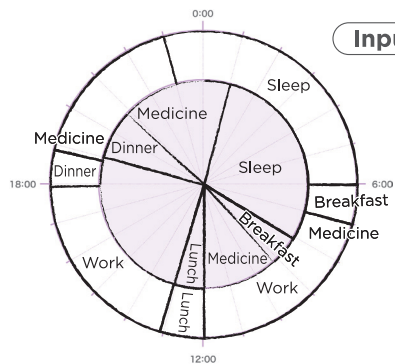
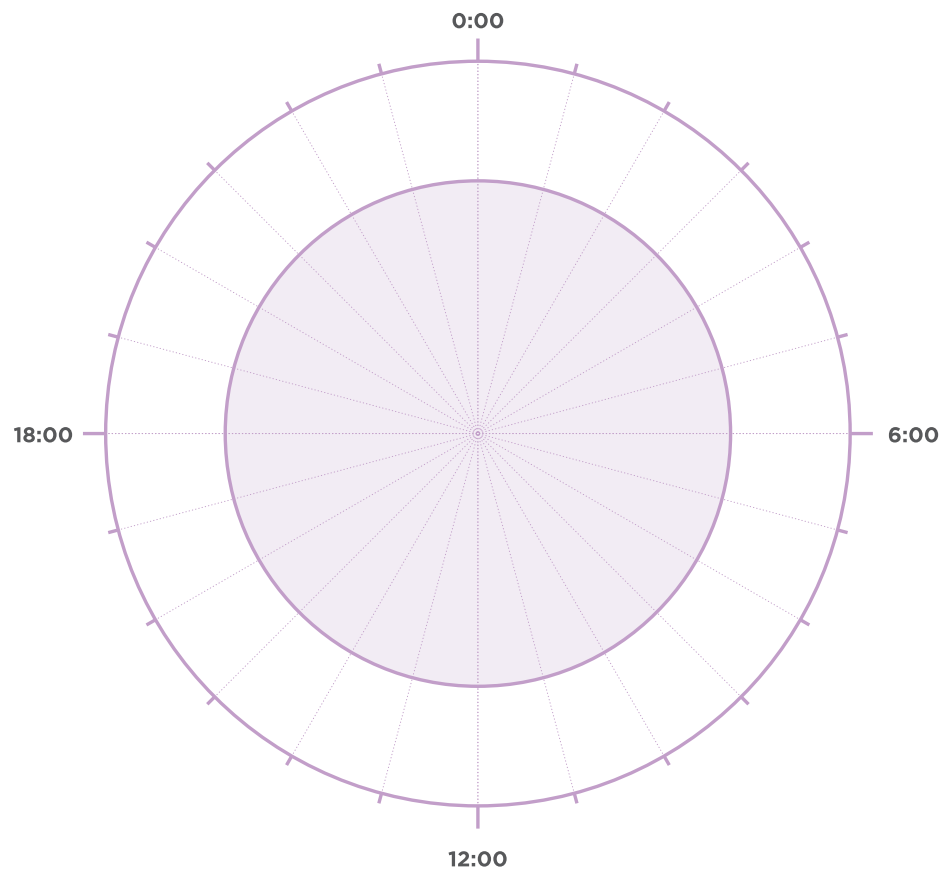


Input example



Input your most typical daily schedule by referring to the input example.



- Usual
- Other times



Inquiries:

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Let's Talk!

## Is there anything troubling you about the medicine that you are taking right now?

Medicine comes in different shapes, sizes, and intake methods.

Consult with your physician about what medicine will be most suited to your lifestyle.



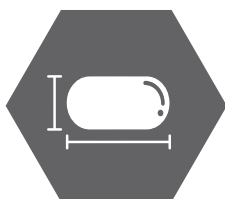
I need to take a large quantity at one time



It is hard for me to take medicine twice a day



I have difficulty because I need to have a meal before taking medicine



The medicine is large and I have difficulty swallowing it



I'm worried about its effects with other medicines or foods

- Which medicine to prescribe is determined comprehensively, not just by looking at the patient's lifestyle, but also by the condition of the patient and whether there is ongoing treatment for other illnesses, etc.
- Even if the medicine is changed in order to reduce side effects or to improve ease of intake, it does not mean that you will have fewer choices of medicines as long as the change is made in accordance with the procedures designated by the physician (if the new medicine does not agree with you, you can also go back to what you took before).
- Medicines are advancing every year. New medicines may now be available that better suit your needs.

## Ask if there are any medicines that are better suited to you

It is important to choose a medicine that suits you in order to be able to take it on a continuous basis.

Inform the following to your physician, pharmacist, and nurse:

- Issues that you are troubled by with regard to the medicine that you are taking now
- Your daily routine and lifestyle
- All of the medicine that you have been prescribed at other medical institutions (show your medical record handbook)

memo

### About your lifestyle overall

1	My daily routine is irregular.	Yes	No
2	I feel a lot of stress from work, household chores, school, etc.	Yes	No
3	I drink alcohol regularly (3 days a week or more).	Yes	No
4	Recently, I haven't had much of an appetite.	Yes	No
5	Recently I have had trouble sleeping, or I wake up in the middle of the night.	Yes	No

### About other illnesses and medications

6	I have an illness that I am receiving continuous treatment for.	Yes	No
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▶ If yes, what kind of an illness is it?

7	I have another medication or supplement, etc. that I am taking other than meals.	Yes	No
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▶ If yes, what is it?

8	There are supplements that I wish to try.	Yes	No
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▶ If yes, what are they?

### About current treatments

9	I feel lethargic on a regular basis.	Yes	No
10	There are times when I feel queasy in my chest or stomach area.	Yes	No
11	There are times when I feel insecure or depressed.	Yes	No
12	There are times when I have headaches or dizziness.	Yes	No
13	There are times when I forget to take my medicine.	Yes	No

▶ If yes, when?

14	The medicine is large and difficult to swallow.	Yes	No
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15	I wish to reduce the number of tablets/capsules or the frequency of intake.	Yes	No
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