Additional file 2. Questionnaire

Questionnaire ROADMAP-study

Study number. _ _ _ _ *Moment: T _ _* *Date: _ _ /_ _/_ _ _ _*

1. As a result of taking this medication, do you experience any side effects at all?

Yes ☐ *No* ☐ → ***If 'No' you may skip question 2 to 5. Please continue with question 6***

2. What side effects do you experience?

. . . . . .

. . . . . .

3. How bothersome are the side effects of the medication you take to treat your condition?

Not at All ☐ ☐ ☐ ☐ ☐ *Extremely bothersome*

4. To what extent do the side effects interfere with your <u>physical health</u> and ability to function (i.e., strength, energy levels etc.)?

Not at All ☐ ☐ ☐ ☐ ☐ *A Great Deal*

5. To what extent do the side effects interfere with your <u>mental function</u> (i.e., ability to think clearly, stay awake etc.)?

Not at All ☐ ☐ ☐ ☐ ☐ *A Great Deal*

6. How easy or difficult is it to use the medication in its current form?

Very easy *Extremely Difficult*

☐ ☐ ☐ ☐ ☐

7. How easy or difficult is it to plan when you will use the medication each time?

Very easy *Extremely difficult*

☐ ☐ ☐ ☐ ☐

8. How convenient or inconvenient is it to take the medication as instructed?

Very convenient *Extremely inconvenient*

☐ ☐ ☐ ☐ ☐

9. Did your study medication change compared to previous study visit?

Yes *No*

☐ ☐ → ***If yes, please specify:***

Which medicine? . . . . . .

By whom?: . . . . . .

When? . . . . . .

Why? : . . . . . .

10. Do you sometimes skip medication?

Frequently *(daily)*	Regularly *(few times a week)*	Sometimes *(Once a week)*	Rarely	Never
☐	☐	☐	☐	☐

This is the end of this questionnaire. Thank you!