Herbal Formula in the Management of Type 2 Diabetes Mellitus: A Three-Arm, Open-Label, Non-Inferiority Randomized Controlled Trial

Medication Adherence Questionnaire

Participant Code: _____

Purpose: This questionnaire is designed to assess how well you follow your prescribed medication regimen. Understanding your medication adherence helps us evaluate its impact on your health outcomes and identify any challenges you may be facing in managing your medications.

Instructions: Please answer the following questions about your medication-taking habits. Your responses will be confidential and are only for research purposes.

1. **How often do you take your medications exactly as prescribed?**
   - ☐ Always
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
2. **In the past month, how often have you missed a dose of your medication?**
   - ☐ Never
   - ☐ 1-2 times
   - ☐ 3-4 times
   - ☐ 5 or more times
3. **If you missed doses, what was the main reason? (Check all that apply)**
   - ☐ Forgot
   - ☐ Side effects
   - ☐ Felt better and thought I didn't need it
   - ☐ Didn't think it was working
   - ☐ Cost issues
   - ☐ Ran out of medication
   - ☐ Difficulty in refilling prescriptions
   - ☐ Other (Please specify): _____
4. **How often do you take your medication at the correct times?**
   - ☐ Always
   - ☐ Most of the time
   - ☐ Sometimes
   - ☐ Rarely
   - ☐ Never
5. **Have you ever stopped taking your medication without consulting your healthcare provider?**
   - ☐ Yes (Please specify why): _____
   - ☐ No
6. **How confident are you that you understand the instructions for taking your medication?**
   - ☐ Very confident
   - ☐ Confident
   - ☐ Somewhat confident
   - ☐ Not confident
7. **Do you use any reminders to take your medication?**
   - ☐ Yes, I use a pillbox
   - ☐ Yes, I set alarms or use an app
   - ☐ No, I rely on memory
   - ☐ Other (Please specify): _____
8. **Have you experienced any side effects from your medication that made it difficult to take them as prescribed?**
   - ☐ Yes (Please specify): _____
   - ☐ No
9. **Do you feel that your medication is helping you manage your condition effectively?**
   - ☐ Yes
   - ☐ No
   - ☐ Not sure
10. **Have you discussed any concerns about your medication with your healthcare provider?**
    - ☐ Yes
    - ☐ No
    - ☐ Not applicable