BAR CODE, NAME, MR# HERE
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Demographics

Today's Date: | ***DOB:*** | ***I have been here before:*** ❑ Yes ❑ No

Current Age: | ***SS#:***

Last Name: | ***First Name:*** | ***MI:***

Address:

Apt #: | ***City:*** | ***COUNTRY of birth:***
❑ USA ❑ Mexico ❑ Burma ❑ Thailand
❑ Other: _____

State: | ***County:*** | ***Zip code:*** | ***Languages Spoken:***
❑ English ❑ Burmese
❑ Spanish ❑ Other_____

Race:
❑ Black/African American
❑ White
❑ American Indian/Alaska Native
❑ Native Hawaiian or Pacific Islander
❑ Asian
❑ Prefer not to answer

Ethnicity:
❑ Hispanic or Latino
❑ Not Hispanic or Latino
❑ Prefer not to answer

Gender: ❑ Male ❑ Female ❑ Transgender, male to female ❑ Transgender, female to male

Home/Cell Phone: _____-_____-_____
Ok to leave message? ❑Yes ❑ No

Work Phone: _____-_____-_____
Ok to leave message? ❑Yes ❑ No

Alternate: _____-_____-_____
Ok to leave message? ❑Yes ❑ No

E-mail address: | ***Preferred method of contact:*** ❑ Phone ❑ E-mail

Employment:
❑ Full time
❑ Part time
❑ Unemployed
❑ Student

Place of Employment/School:

Current yearly individual income:
❑ Less than $10,000
❑ $10,000-$19,000
❑ $20,000-$29,000
❑ $30,000-$39,000
❑ $40,000 or more
❑ Declined

Marital Status:
❑ Single
❑ Divorced
❑ Married
❑ Separated
❑ Widowed

Health Insurance Provider: ❑ None ❑ Private through an employer ❑ Medicaid ❑ Medicare ❑ Other

Health History

ALLERGIES
❑ None
❑ Penicillin ❑ Cephalosporins ❑ Sulfa drugs ❑ Baker's Yeast ❑ Eggs
❑ Tetracycline ❑ Quinolones ❑ A Vaccine ❑ Other: _____

I take the following medications (please list):

Birth Control Method:

In the last 14 days, I have: ❑ Taken an antibiotic ❑ Seen another healthcare provider

I now have or have had the following health concerns in the past:

❑ High Blood Pressure
❑ Heart Disease
❑ Asthma
❑ TB Infection
❑ Blood Clots
❑ Cancer
❑ Seizures
❑ Diabetes
❑ Kidney Problems
❑ Urinary Tract Infection
❑ Smoker
❑ Chewing Tobacco Use
❑ Injection Drug Use
❑ Non-injection Drug Use
❑ Alcohol Use
❑ Antabuse Treatment
❑ Hepatitis B
❑ Hepatitis C
❑ HIV
❑ Herpes
❑ Gonorrhea
❑ Chlamydia
❑ Trichomoniasis
❑ Urethritis/Cervicitis
❑ Syphilis
❑ HPV/warts
❑ Molluscum
❑ Other:

I have received the following immunizations:
❑ HPV (Gardasil) ❑ Hepatitis B ❑ Hepatitis A ❑ Tdap (tetanus with pertussis) ❑ Influenza ❑ Pneumococcal

Family Doctor: | ***Referring Doctor:***

Reason for Today's Visit

I AM HERE TODAY BECAUSE (please check the box):
❑ I would like a routine STD exam
❑ WITH HIV testing ❑ WITHOUT HIV testing
❑ I need a 3 month follow-up check-up after infection
❑ I received a letter or phone call from the clinic
❑ I would like HIV testing ONLY
❑ I am having symptoms
Please check all that apply:
❑ Discharge ❑ Burning ❑ Sores ❑ Itching
❑ Pain ❑ Warts ❑ Rash ❑ Other (specify below):

❑ Partner sent me
❑ Current Partner ❑ Past Partner

Partner's Name:

Partner's Problem:

Partner Treated:
❑ Yes Where: _____ When: _____
❑ No

Sexual History

I was first sexually active at the age of: ❑ before 13 ❑ 13 ❑ 14 ❑ 15 ❑ 16 ❑ 17 ❑ 18 or older

# of Sex Partners in the 60 days: ❑ None ❑ 1 ❑ 2 -9 ❑ 10 or more

# of Sex Partners in the Last 12 months: ❑ None ❑ 1 ❑ 2 -9 ❑ 10 or more

Please complete the information below about your most recent partners, in the past 12 months.

	Gender of Partner: M = Male F = Female T = Transgender	Date of Last Sex with each partner	Parts of Body Used For Sex V =Vagina P = Penis B = Butt M = Mouth		Used Condom?	® = Regular or © = Casual Partner
			YOU	**PARTNER**		
1	❑ M ❑ F ❑ T		❑ V ❑ P ❑ B ❑ M	❑ V ❑ P ❑ B ❑ M	❑Yes ❑ No	❑® ❑ ©
2	❑ M ❑ F ❑ T		❑ V ❑ P ❑ B ❑ M	❑ V ❑ P ❑ B ❑ M	❑Yes ❑ No	❑® ❑ ©
3	❑ M ❑ F ❑ T		❑ V ❑ P ❑ B ❑ M	❑ V ❑ P ❑ B ❑ M	❑Yes ❑ No	❑® ❑ ©
4	❑ M ❑ F ❑ T		❑ V ❑ P ❑ B ❑ M	❑ V ❑ P ❑ B ❑ M	❑Yes ❑ No	❑® ❑ ©
5	❑ M ❑ F ❑ T		❑ V ❑ P ❑ B ❑ M	❑ V ❑ P ❑ B ❑ M	❑Yes ❑ No	❑® ❑ ©

In the last 12 months, <u>I have</u>:	Y=Yes N=No	Gender of Partner: M = Male F = Female T = Transgender
Injected drugs	❑ Y ❑ N	NA
Shared injection drug equipment	❑ Y ❑ N	NA
Exchanged sex for drugs/money/other	❑ Y ❑ N	NA
Had sex while under the influence of alcohol or drugs	❑ Y ❑ N	NA
Been in prison or jail	❑ Y ❑ N	NA
Been diagnosed with a sexually transmitted infection ❑ Gonorrhea ❑ Chlamydia ❑ Syphilis	❑ Y ❑ N	NA

In the last 12 months, <u>I have had a partner</u> who:	Y=Yes N=No	Gender of Partner: M = Male F = Female T = Transgender
Exchanges sex for drugs/money/other	❑ Y ❑ N	❑ M ❑ F ❑ T
Was under the influence of alcohol or drugs	❑ Y ❑ N	❑ M ❑ F ❑ T
Injects drugs	❑ Y ❑ N	❑ M ❑ F ❑ T
Is HIV positive?	❑ Y ❑ N	❑ M ❑ F ❑ T
Is a man known to have sex with other men	❑ Y ❑ N	❑ M ❑ F ❑ T
I did not use a condom with	❑ Y ❑ N	❑ M ❑ F ❑ T

Other Information

In my lifetime I have:

Been tested for HIV	❑ Y ❑ N	Date of last test:	Where was last test done?	Result: ❑ Pos ❑ Neg

Been the victim of abuse	❑ Y ❑ N	❑ Physical ❑ Sexual ❑ Emotional	❑ Currently ❑ In past
Given or received tattoos	❑ Y ❑ N	❑ In a licensed establishment ❑ In a NON-licensed establishment	❑ Currently ❑ In past
Given or received piercings	❑ Y ❑ N	❑ In a licensed establishment ❑ In a NON-licensed establishment	❑ Currently ❑ In past

FEMALES ONLY

First day of last period:		Age at first period:		I douche	❑ Y ❑ N
Date of last PAP:		I have had an abnormal PAP	❑ Y ❑ N	If YES, date/place of abnormal PAP:	
I am currently pregnant	❑ Y ❑ N	IF YES: I am receiving prenatal care	❑ Y ❑ N	If YES: My due date is	
I am currently breastfeeding	❑ Y ❑ N	I have frequent yeast infections	❑ Y ❑ N	I have frequent bacterial vaginosis infections	❑ Y ❑ N

The information above is true to the best of my knowledge. I understand that falsifying any of the above information could adversely affect decisions made by my health care provider.

Client Signature

Reviewed by