New HIV Patient Questionnaire

Name: | DOB:

PLEASE ANSWER THE FOLLOWING IF YOU ARE LIVING WITH HIV: STATISTICAL PURPOSES ONLY

Race: ☐ White ☐ Black or African American ☐ Asian ☐ Native Hawaiian/Pacific Islander
☐ American Indian/Alaskan Native ☐ Multiracial ☐ Unknown ☐ Other ____________________

Ethnicity: ☐ Hispanic or Latino ☐ Non-Hispanic/Non-Latino ☐ Unknown

Gross Annual Income (Before Taxes): $________________ How many people does this income support?: _______

Housing Situation: ☐ Own ☐ Rent ☐ With Family ☐ Not Permanently Housed

SOURCES OF SUPPORT

Describe your current support system (family, friends, etc): ______________________________

Are you a client of: ☐ BCAP ☐ NCAP ☐ SCAP ☐ CAP ☐ Other ______________________________

- Who is your case manager? ______________________________

Are you interested in learning about our mental health services? ☐ Yes ☐ No

Are you interested in learning about a peer-based support group? ☐ Yes ☐ No

SEXUAL HISTORY AND RISK ASSESSMENT

CONFIDENTIAL! WILL NOT BE RELEASED AS PART OF YOUR MEDICAL RECORD

Number of sexual partners in the last 6 months: ________ ☐ Men ☐ Women ☐ Both

Please check any risk factors that apply to you:	When	Have you had sex with the following:	Protected?
☐ Unprotected sex		☐ A person known to have HIV or AIDS?	☐ Yes ☐ No
☐ Injection drug use		☐ A person known to have Hepatitis C?	☐ Yes ☐ No
☐ Sharing needles used for injection drugs		☐ A man who has sex with men?	☐ Yes ☐ No
☐ Blood transfusion before 1986		☐ Someone who is an injection drug user?	☐ Yes ☐ No
☐ Occupational exposure to blood or body fluids		☐ A person known to be a hemophiliac?	☐ Yes ☐ No
☐ Victim of sexual abuse/assault		☐ A blood transfusion or transplant recipient?	☐ Yes ☐ No

Do you participate in the following:			Receptive Partner?	Do you have any other known risk factors? Please explain.
☐ Oral Sex?	☐ Yes	☐ No	☐ Yes ☐ No	
☐ Anal Sex?	☐ Yes	☐ No	☐ Yes ☐ No	
☐ Vaginal Sex?	☐ Yes	☐ No	N/A	

LABORATORY AND VACCINE HISTORY

Have you had these tests?	Date	Result	Have you had these vaccines?	Dates Received
☐ CD4 T-Cell Count			☐ Influenza	
☐ HIV Viral Load			☐ H1N1 (Swine) Flu	
☐ Toxoplasmosis Titer			☐ Pneumovax (Pneumococcal)	
☐ Pap Smear (Vaginal or Anal)			☐ Tetanus (TDAP or Td)	
☐ TB Skin Test or Quantiferon		☐ Pos ☐ Neg	☐ Hepatitis A	/ /
• If positive: Chest X-Ray		☐ Pos ☐ Neg	☐ Hepatitis B	/ /
☐ Syphilis Test (RPR)		☐ Pos ☐ Neg	☐ Meningococcal	
☐ Gonorrhea		☐ Pos ☐ Neg	☐ Other ______________________	
☐ Chlamydia		☐ Pos ☐ Neg	☐ Other ______________________	
☐ Hepatitis C Antibody		☐ Pos ☐ Neg	☐ Other ______________________	

OTHER QUESTIONS

What are your thoughts on HIV controlling medications (Anti-retroviral therapies)?

Are you interested in participating in a consumer advisory board, which elicits consumer feedback regarding available program services, budgets, and sources of funding? ☐ Yes ☐ No

TOBACCO, ALCOHOL, DRUG SCREENING

Please note: This information is used for screening purposes only. Please answer all questions as honestly as possibly. Data collected here is reported <u>without</u> any identifying information. This form <u>will not</u> be provided to any other office or facility without your express written permission.

Substances prescribed by a physician and taken exactly as prescribed do not need to be reported. However, if you take prescribed medications more often than directed or in a manner other than directed, please include those on this screening. Thank you!

Have you used the following in:	Last 3 Months	Your Lifetime	Have you used the following in:	Last 3 Months	Your Lifetime
☐ Tobacco (Cigarettes, Chewing Tobacco, Cigars, etc	☐Yes ☐No	☐Yes ☐No	☐ Inhalants (nitrous, glue, petrol, paint thinner, etc)	☐Yes ☐No	☐Yes ☐No
☐ Alcoholic beverages (beer, wine, spirits, etc)	☐Yes ☐No	☐Yes ☐No	☐ Sedatives (Ativan, Xanax, Valium, Rohypnol, etc)	☐Yes ☐No	☐Yes ☐No
☐ Amphetamine/Stimulants (Speed, diet pills, ecstasy, etc)	☐Yes ☐No	☐Yes ☐No	☐ Hallucinogens (LSD, acid, PCP, mushrooms, Special K, etc)	☐Yes ☐No	☐Yes ☐No
☐ Cocaine (coke, crack, etc)	☐Yes ☐No	☐Yes ☐No	☐ methadone, codeine, etc)	☐Yes ☐No	☐Yes ☐No
☐ Cannabis (marijuana, pot, grass, hash, etc)	☐Yes ☐No	☐Yes ☐No	☐ Other (please specify): ________________ ________________	☐Yes ☐No	☐Yes ☐No
• Are you on the marijuana registry?	☐ Yes	☐ No			