Metro Health STD/HIV Risk Assessment Form

Date of visit: _____

PATIENT INFORMATION

Patient Name: _____ **Date of Birth:** _____
Patient Signature: _____
Social Security #: _____ **Phone #:** (_____) _____ **E-mail:** _____
Address: _____ **Apt #:** _____ **City:** _____ **County:** _____ **State:** _____ **Zip Code:** ____
Race: [] White [] Black/African American [] Asian [] American Indian/Alaskan Native [] Native Hawaiian/Pacific Islander [] Other

Ethnicity:
[] Hispanic / Latino
[] Not Hispanic / Latino

Gender:
[] Male
[] Female
[] Transgender
[] Male to Female
[] Female to Male

Sex Assigned at Birth:
[] Male [] Other
[] Female

Emergency Contact Name: _____ **Relationship** _____ **Phone #:** (____) _____
Would you like to sign up for our patient portal? [] Yes **[]** No **[]** I already have an account (Please list email above)
Marital Status: [] Married [] Single [] Polyamorous [] Other
Have you lived or recently traveled outside of the United States? [] YES [] NO If Yes, Where? _____
When was the last time you were at this clinic? _____
Are you here with your partner? [] YES [] NO If yes, (Partner's Clinic Number today _____)
What is your primary language? _____

MEDICAL BACKGROUND

YES NO Are you currently pregnant? ***START*** **OF LAST MENSTRUAL CYCLE:** _____
YES NO **Are you allergic to any medication?** If yes, which ones: _____ Reactions: _____
YES NO **Are you being treated for a medical condition at this time?** If yes, which ones: _____
YES NO **Are you currently taking any medications?** If yes, which ones: _____
YES NO **Do you currently use tobacco products of any kind (including vape)?**
If yes, do you want information on how to quit tobacco or vape? [] YES [] NO
YES NO **Have you ever been tested for HIV/STDs?**
If yes, which one(s): _____ Date of test: Month _____Year _____
YES NO **Have you even been told you have HIV, Syphilis, Hepatitis C, Chlamydia or Gonorrhea?**
If yes, which one(s)? _____ When? _____
YES NO **Have you ever been treated for an STD?** If yes, what treatment did you receive? _____
When? _____ Who provided treatment? _____

What is the reason for your visit today?

[] STD/HIV Screening / Testing
[] Preventive Treatment
[] My partner was diagnosed with an infection:
Chlamydia HIV
Gonorrhea Trichomoniasis
Syphilis I am not sure of the infection
Other: _____

Did someone tell you to come in today?

[] No
[] Yes, for Chlamydia or Gonorrhea
[] Yes, for Syphilis
If yes, please tell us who asked you to come in:
Staff member from our clinic: _____
Partner Name _____
DOB: _____
Other _____

Are you having any of the following symptoms?

[] No
[] Abdominal Pain/Fever/Scrotal Pain, N/V
[] Bleeding /Nausea /Vomiting
[] Discharge (vagina /penis /rectum) **Color:** _____
[] Sores (NOT soreness)/Rash/Bumps: **Where:** _____
[] Blisters/Warts: **Where:** _____
[] Itching**: Where**: _____
[] Pain while urinating
[] Other: _____

Assigned Male at Birth (AMAB) In the past 90 days, did you:
Have sex with person(s) AMAB? ___ YES___NO
If yes, do you top (where you place your penis in your sex partner's rectum) [] YES [] NO
Do you bottom? (where you receive your sex partner's penis in your rectum) [] YES [] NO
Had sex in a public place like a bathhouse, bookstore, parking lot? [] YES [] NO

In the past 90 days, have you:
YES NO Had more than one sexual partner? **YES NO Picked up someone you did not know to have sex with them?** **YES NO Met someone for sex whom you met online? If yes, which site?** _____ **YES NO Exchanged sex for money, drugs, food, shelter, and / or other items?** **YES NO Knowingly had sex with a sex worker / prostitute?** **YES NO Used drugs like crack cocaine, crystal meth, or other IV drugs?** If yes, do you share drug equipment? [] YES [] NO If yes, how many needle-sharing partners have you had in the past 90 days? _____ **YES NO Have you engaged in any sexual behavior with a person of the same sex assigned at birth (voluntary or involuntary)?** **YES NO Have you had sex with someone you know has Syphilis, Gonorrhea, Chlamydia, Hepatitis, HIV?** If yes, which one(s)? _____ **YES NO Had sex with somebody in a public place like a bar / club, bathhouse, book store, or public park?** If yes, where? _____ **How often do you use condoms or other protective barriers?** [] ALWAYS [] SOMETIMES [] NEVER [] PICK UPS ONLY

Additional Questions:	
My Sex Partners Are: **[] Male** **[] Female** **[] Transgender Men** **[] Transgender Women**	**# of Sexual Partners in past 6 months:** **Males: _____** **Females: _____** **Transgender Men: _____** **Transgender Women: _____**
In your opinion, what are your chances of getting an STD or HIV? [] Low Chance [] Moderate Chance [] High Chance	**Why do you think you are at this level of risk?** _____

Please answer the following questions:
YES NO Have you ever heard of PrEP? **YES NO Are you currently taking daily PrEP medication?** **YES NO Have you used PrEP anytime in the last 12 months?** **YES NO Would you like a referral for PrEP services?** **YES NO Have you ever had oral, vaginal, and/or anal sex while drunk and/or high on drugs?** **YES NO Have you ever been incarcerated (jail, prison, penitentiary)?** **YES NO Have you seen a demonstration on how to use a male/female condom?** **YES NO Have you ever had unprotected sex (oral, vaginal, or anal)? If yes, which one? _____**

****For Internal Staff Use only ****		
Test requested: [] HIV [] Syphilis [] Gonorrhea/Chlamydia [] HCV [] HBV		
Drawn By:	**Time collection:**	
PrEP Screening: **Is the client at risk for HIV?** [] YES [] NO **Was the client screened for PrEP eligibility?** [] YES [] NO **Is the client eligible for PrEP referral?** [] YES [] NO **Was the client given a referral to a PrEP provider?** [] YES [] NO **Was the client provided with services to assist with linkage to a PrEP** [] YES [] NO	**Referral Given:** [] YES [] NO **Type of Referral:** _____ _____ _____ **Risk Reduction Step:** _____ _____ _____ _____ _____	**Notes/Comments:** _____ _____ _____ _____ _____ **Unique Identifiers:** _____ _____ _____ _____ _____