CENTER FOR PREVENTION AND TREATMENT OF INFECTIONS

Medical History Form

Name: _____ Date:_____

DOB:_____ Reason For Visit: _____

Primary Care Physician:_____ Referring Physician:_____

Date of last Negative HIV test:_____ Date of first Positive HIV test:_____

Past Medical History: Have you **ever had OR do you currently have** any of the following: (Please Circle)

Rheumatic fever	COPD	Hepatitis
Heart Attack	Heartburn	Psychiatric Illnesses
Congestive Heart Failure	Ulcers	Anxiety
High Blood Pressure	Thyroid Disease	Depression
Stroke	PCP (Pneumonia)	Neuropathy
Seizure	TB	Skin Disorders
High Cholesterol	Mycobacterium	Prostate Problems
Blood Disorder	Esophageal Candidiasis (Thrush)	Kidney Infections
Anemia	Cytomegalovirus	Bladder Infections
Cancer	Shingles (Herpes Zoster)	Gallbladder Disease
Asthma	Toxoplasmosis	Sexually Transmitted Diseases

If you answered yes to any of the above please explain:

_____

_____

Other Chronic Medical Conditions **Not** Listed Above:

_____

_____

Medication Allergies:

Medication: Reaction: Medication: Reaction:

_____ _____

_____ _____

Other Allergies Not Listed Above**:**

_____

_____

Immunizations: Have you ever been immunized for?

Tetanus _____ When? _____ Pneumonia _____ When? _____

Hepatitis A _____ When? _____ Hepatitis B _____ When? _____

Influenza _____ When? _____

Date of last TB test? _____ Positive/Negative? _____ If Positive did you receive treatment?_____

Family History: Please list family members medical conditions

	Current Age	Age at death	Cause of Death	Chronic Medical Conditions
Mother:				
Father:				
Brothers:				
Sisters:				
Children:				

Social History:

Highest Grade Completed: _____ Occupation: _____

Single: _____ Married: _____ Divorced: _____ Widow: _____

Have you ever had sex with? Men: _____ Women: _____ Both: _____

Are you currently in a monogamous relationship? _____

Are you currently sexually active? _____ Do you use protection **ALL** the time? _____

Do you smoke or chew tobacco? _____ If yes, how much? _____

If no, did you ever smoke/chew? _____ When did you quit smoking/chewing? _____

Do you drink alcohol? _____ How much and what do you drink? _____

Do you currently use opiates? _____ Have you ever used opiates? _____

Do you currently use Amphetamines? _____ Have you ever used Amphetamines? _____

Do you currently use Cocaine? _____ Have you ever used Cocaine? _____

Do you currently use Marijuana? _____ Have you ever used Marijuana? _____

Do you have any pets? _____ What type? _____

Have you recently traveled outside the US? _____ Where? _____

Date of Last Colonoscopy? _____ Results? _____

Do you have a Living Will/Power of Attorney? _____ Durable Power assigned? _____

For FEMALES ONLY:

First day of last menstrual period? _____ Date of Last Mammogram? _____

Date of Last PAP? _____ Have you ever had an abnormal PAP? _____

Are you pregnant? _____ How many weeks? _____ Any complications? _____

Current Medications:

Medication:	Dose:	Medication:	Dose:

Prior Antiretroviral Medications:

Medication:	Dates Taken:	Side Effects:	Reason Stopped:

Surgical/Hospitalization History:

Surgery/Hospitalization:	Reason:	Date:

Review of Systems: Do you **CURRENTLY** have any of the following? (Please circle)

Gen:	Fever	Chills	Night Sweats	Weight Loss	Fatigue
Skin:	Rash	Itching	Bruising		
HEENT:	Headache	Blurred/Double Vision	Decreased Hearing	Earache	
Neck:	Pain	Stiffness	Swelling		
Resp:	Cough	Sputum	Shortness of Breath		
CV:	Chest Pain	Irregular Heart Beat	Leg Cramps		
GI:	Abdominal Pain	Swelling	Nausea	Change in Bowel Habits	
GU:	Burning with urination	Frequent Urination	Difficulty emptying bladder		
MS:	Joint Pain	Joint Swelling	Joint Stiffness	Muscle Pain	Muscle Weakness
Neuro:	Dizziness	Imbalance	Numbness		
Psych:	Difficulty sleeping	Depression	Anxiety	Memory Difficulty	
Endo:	Change in Appetite	Sexual Problems			
Heme:	Nose Bleeds	Enlarged Glands			

CENTER FOR PREVENTION AND TREATMENT OF INFECTIONS

Confidential Risk Assessment Form

Name: _____ DOB: _____

Date of last negative HIV test? _____ Age at time of Diagnosis? _____

Race: _____ Country of Birth: _____

Your address at the time of HIV/AIDS diagnosis:

_____

_____

_____

_____

Name and Facility where you were diagnosed:

_____

_____

_____

_____

Date of 1st Positive HIV test: _____ Can you get a copy of this record for our office: _____

HAVE YOU EVER:

1. Worked in a health-care or clinical laboratory setting? YES NO
2. Received transplant tissue/organ or artificial insemination? YES NO
3. Received a blood transfusion? YES NO
   - If yes, what was the year and month of transfusion? _____
   - Name and Address of Hospital where you had the transfusion:

     _____

     _____
   - What was the reason for the transfusion? _____

HAVE YOU EVER HAD SEXUAL RELATIONS WITH ANY OF THE FOLLOWING:

1. IV drug user? YES NO
2. Bisexual male? YES NO
3. Person with hemophilia? YES NO
4. Transfusion recipient with documented HIV infection? YES NO
5. Transplant recipient with documented HIV infection? YES NO
6. Person with HIV or AIDS? YES NO

HAVE YOU EVER HAD:

1. Sex with a male? YES NO
2. Sex with a female? YES NO

Have you ever injected nonprescription drugs? YES NO

Are you a hemophiliac? YES NO

FOR WOMEN ONLY:

1. Are you under the care of a gynecologist? YES NO
   - Who? _____
2. Are you currently pregnant? YES NO
   - If yes, estimated delivery date? _____
3. Have you delivered live-born children? YES NO
   - If yes, when was the most recent birth? _____
   - What is the name and address of the hospital where the birth occurred?

     _____

     _____