PATIENT#: _____ **DATE:** _____

Welcome to The Miriam Hospital HIV/STI Clinic

All answers are confidential. We ask about some of your behaviors so we can appropriately screen you for certain STIs.

First Name:_____ **Last Name:**_____ **Date of Birth:**_____
Zip code you live in:_____ **Phone Number:**_____ **(to call with results)**

What is your gender identity: Man Woman Transwoman Transman Genderqueer/Agender/Nonbinary Other: _____
What was your assigned sex at birth: Male Female Intersex
How do you identify: Heterosexual Gay Lesbian Bisexual Queer Pansexual Asexual Other: _____
Race: Caucasian/White African American/Black Asian Pacific Islander Native American Other: _____
Ethnicity: Hispanic/Latino Not Hispanic/Latino
Do you have Health Insurance: None Medicaid Medicare Private Other: _____

Where did you hear about this clinic? Department of Health Friend Partner Google
Scruff Grindr Facebook Twitter Poster/Flier Other: _____
Have you heard of the DoItRIght Campaign? NO YES **If so, where**:_____

Have you ever had an HIV test before? YES NO **If yes**, how long ago were you tested? _____
Have you ever had a positive HIV test? YES NO **If yes**, what year? _____

What is your risk of becoming HIV infected? No Risk Low-Risk Medium-Risk High-Risk N/A

Men Complete the Following Questions:

In the past 12 months, with how many MEN have you had anal sex with:
Receptive (**only** bottom):____ **Insertive** (**only** top):____ **Both** (Vers):____
How many have you **not** used a condom with:____
How many are known to be HIV positive:____
How many are known to use injection drugs:____

In the past 12 months, with how many WOMEN have you had vaginal/anal sex with:____
How many have you **not** used a condom with:____
How many are known to be HIV positive:____
How many are known to use injection drugs:____

In the past 12 months, with how many people have you had oral sex with: **MEN:**____ **WOMEN:**____
How many have you **not** used a condom with:____
How many are known to be HIV positive:____
How many are known to use injection drugs:____

Women Complete the Following Questions:

In the past 12 months, with how many MEN have you had vaginal/anal sex with: ____
Vaginal sex only:____ **Anal sex only:**____ **Both:**____
How many have you **not** used a condom with:____
How many are known to be HIV positive:____
How many are known to use injection drugs:____
How many men are known to have sex with other men? ____

In the past 12 months, with how many people have you had oral sex with: **MEN:**____ **WOMEN:**____
How many have you **not** used a condom with:____
How many are known to be HIV positive:____
How many are known to use injection drugs:____

In the past 12 months, have you…

Exchanged sex for drugs/money/something else you needed?	**YES**	**NO**
Had sex with a person that exchanges sex for drugs/money?	**YES**	**NO**
Had sex with an anonymous partner (i.e. one night stand)?	**YES**	**NO**
Had sex while intoxicated and/or high on drugs?	**YES**	**NO**
Had sex with someone you did not know their HIV status?	**YES**	**NO**
Been diagnosed with an STI?	**YES**	**NO**
Used amphetamines (i.e. Meth, Tina)?	**YES**	**NO**
Used poppers?	**YES**	**NO**
Met partners online?	**YES**	**NO**

If yes, site(s):_____

Have you EVER…

Been incarcerated (i.e. in jail/prison)?	**YES**	**NO**
Been forced to have sex?	**YES**	**NO**
Had an STI?	**YES**	**NO**
If yes, which one(s):_____		
Injected drugs?	**YES**	**NO**
If yes, did you ever share needles?	**YES**	**NO**

Last injection:_____

Which of the following substances have you used:
**For prescription medications, please report nonmedical use only*

	Lifetime	Past 30 Days
1. Cannabis (marijuana, pot, grass, hash, etc.)	☐	☐
2. Cocaine (coke, crack, etc.)	☐	☐
3. Prescription stimulants (Ritalin, Concerta, Dexedrine, Adderall, diet pills, etc.)	☐	☐
4. Methamphetamine (speed, crystal meth, ice, etc.)	☐	☐
5. Inhalants (nitrous oxide, glue, gas, paint thinner, etc.)	☐	☐
6. Sedatives or sleeping pills (Valium, Serepax, Ativan, Librium, Xanax, Rohypnol, GHB, etc.)	☐	☐
7. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, ecstasy, etc.)	☐	☐
8. Street opioids (heroin, opium, etc.)	☐	☐
9. Prescription opioids (fentanyl, OxyContin, Percocet, Vicodin, methadone, buprenorphine, etc.)	☐	☐
10. Other – Specify:_____	☐	☐

☐ **Never Used Any of the Above Substances**

How often do you have a drink containing alcohol?
☐ Never ☐ 2-3 times a week
☐ Monthly or less ☐ 4 or more times a week
☐ 2-4 times a month

How many drinks containing alcohol do you have on a typical day when you are drinking?
☐ 1 or 2 ☐ 5 or 6 ☐ 10 or more
☐ 3 or 4 ☐ 7 to 9

*A drink should be considered equal to one beer, one glass of wine, or one shot of liquor

How often do you have six or more drinks on one occasion?
☐ Never ☐ Weekly
☐ Less than Monthly ☐ Daily or almost daily
☐ Monthly

Have you ever tested positive for (*Circle all that apply*): HEPATITIS A HEPATITIS B HEPATITIS C NONE
Have you been vaccinated for (*Circle all that apply*): HEPATITIS A HEPATITIS B HPV NONE NOT SURE

Have you heard of taking HIV medications after a possible sexual exposure to prevent HIV infection? (Post-exposure prophylaxis, **PEP**) YES NO
Have you ever taken post-exposure prophylaxis (**PEP**)? YES NO

Have you heard of taking HIV medications to prevent infection in people who are HIV negative? (Pre-exposure prophylaxis, **PrEP**) YES NO
Have you ever taken pre-exposure prophylaxis (**PrEP**)? YES NO
Are you currently taking pre-exposure prophylaxis (**PrEP**)? YES NO

Has a partner of yours recently been diagnosed with an STI? YES NO Were you referred by The Department of Health? YES NO
Do you have any symptoms today? NO YES (IF YES, PLEASE DESCRIBE:_____**)**

COMPLETE FRONT PAGE ONLY

Version 12-2018

THIS PAGE TO BE COMPLETED BY MEDICAL PROVIDER

Reason for visit: Routine Screening:__ Follow-up:__ Other: _____ Symptoms: Yes__ No__
Do you have Health Insurance? YES NO
If yes, what type? Blue Cross Blue Shield United Health Care (Private) United Health Care (RItecare) Medicaid Medicare Cigna Aetna Tufts Other:_____
How are you covered? Self-insured Parent's insurance Partner's insurance Other:_____

History of Present Illness:

How long have you had these symptoms? _____
Do you have a partner with symptoms? YES NO

Review of Symptoms:

Pain when urinating	___	Rectal pain	___	Fevers/chills	___
Pain with vaginal sex	___	Rectal itching	___	Sore throat	___
Pelvic Pain	___	Rectal bleeding	___	Muscle/joint aches	___
Vaginal or penile		Pain with	___	Cough	___
discharge/dripping	___	defecation/pooping		Headache	___
Genital ulcers	___	Pain with anal sex	___	Congestion	___
Painful?	___	Painful lymph nodes	___	Other symptoms:	
Genital Odor	___	Rash	___		

Past Medical History: _____
Psychiatric History: _____
Current Medications: _____
Do you have any DRUG ALLERGIES? YES NO
If YES, medication/reaction: _____

Physical Exam:
General: □ AAO x3 □ In no acute distress □ Other: _____
Lymphadenopathy: □Cervical □ Inguinal □ Other: _____
Skin:
Genitals:

LABORATORY	RESULTS
□ **Rapid HIV**	_____
□ **Serum HIV Ab**	_____
□ **Serum HCV Ab**	_____
□ **HCV Viral Load**	_____
□ **TP IgG Ab**	_____
□ **RPR**	_____
□ **TP-PA**	_____
□ **Urine GC**	_____
□ **Urine CT**	_____
□ **Oral GC**	_____
□ **Oral CT**	_____
□ **Rectal GC**	_____
□ **Rectal CT**	_____
□ **Trichomonas**	_____

TREATMENT

□ **Benzathine Penicillin G IM 2.4 million units**
□**Once** □ **Once a week for 3 weeks**
□ **Ceftriaxone 250mg IM once**
□ **Azithromycin 1g PO once**
□ **Azithromycin 2g PO once**
□ **Metronidazole 2g PO once**
□ **Metronidazole 500mg PO Q12, 7 days**
□ **Doxycycline 100mg PO Q12,_____ days**
□ **Gemifloxacin 320mg PO once**
□ **Gentamicin 240mg IM once**

ORDERED BY:_____

TREATED BY:_____

OTHER TESTS/TREATMENT

□_____
□_____
□_____
□_____
□_____

If the patient reports substance use in the past 30 days:
Are you interested in learning more about potential treatment options for alcohol and/or substance use?
□ Yes (information/referral sheet provided) □ No, reason:_____ □ Did not discuss, reason:_____

Partner Notification Services (To be completed if the patients is positive for syphilis or gonorrhea):
Was the patient referred for partner notification services: □ Yes, RIDOH DIS staff □ Yes, TMH staff □ No
If no, why not? □ Patient refused □ Patient was treated at the time of testing and did not return to clinic after positive results
□ Provider forgot to refer □ DIS not at clinic □ DIS in with another patient □ Other:_____

Pre-Exposure Prophylaxis (PrEP) education:
Was PrEP discussed? □ No □ Yes
If no, why not? □ Not MSM □ Already talked to before □ Refused □ HIV+ □ On PrEP □ Other:_____
If yes, were the following discussed: □ What is PrEP □ Who should use PrEP □ Adherence □ Side Effects
Questions or concerns: _____

Additional Comments/Notes:

_____

_____

_____

_____