Quick Check

Answer the questions below and have a seat. You will be called by the number listed on this form.

Check-In # 85

Name: DOB: MRN/Chart#

1.	Have you ever been seen at this clinic?	☐ Yes ☐ No
2.	Are you currently pregnant or do you believe you may be pregnant?	☐ Yes ☐ No
3.	Are you here for results only?	☐ Yes ☐ No
4.	Is your sex partner here today?	☐ Yes ☐ No
5.	Do you have a rash?	☐ Yes ☐ No
6.	Do you have a sore on your penis, vagina or rectum (butt)?	☐ Yes ☐ No
7.	Do you have burning or discomfort with urination (pee)?	☐ Yes ☐ No
8.	Do you have discharge from your penis, vagina or rectum (butt)?	☐ Yes ☐ No
9.	Do you have testicular pain?	☐ Yes ☐ No
10.	For Females only, do you have lower abdominal pain?	☐ Yes ☐ No
11.	Did a sex partner tell you to get tested or that they have an STD/HIV?	☐ Yes ☐ No
12.	Did someone from this Clinic call you to come in?	☐ Yes ☐ No
	Name of Staff Member _____	
13.	Have you been sent here by a doctor or medical facility or do you a positive lab result?	☐ Yes ☐ No
14.	Are you here for court ordered HIV testing?	☐ Yes ☐ No
15.	I have no symptoms listed above, I just want to be tested.	☐ Yes ☐ No
16.	Other reason not listed on this form: _____	