

CLIENT DEMOGRAPHICS

What is the first letter of your last name? _____

What is your date of birth? _____

M	M	D	D	Y	Y
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What is your gender? (mark one)

- Male
- Female
- Pregnant? Yes No D/K
- If yes, in prenatal care? Y N
- Referral to prenatal care? Y N
- Transgender (MTF)
- Transgender (FTM)
- Intersex
- Additional: _____
- Declined/Don't know

What is your ethnicity? (mark all that apply)

- Black/African American
- Native American
- Asian
- Pacific Islander
- Hispanic/Latino(a)
- White
- Other: _____
- Declined/Don't know

What is your sexual orientation? (mark one)

- Gay/Lesbian/Queer
- Bisexual
- Heterosexual/Straight
- Other: _____
- Declined/Don't know

What is the zip code where you currently reside? _____

- Client resides outside CA
- Declined/Don't Know

What is your housing status? (mark one)

- Permanent (own/rent)
- Temporary (with friend/SRO)
- Homeless/Shelter
- Declined/Don't Know

Have you been incarcerated in the past 12 months?

- Yes
- No
- Declined/Don't Know

What type of health insurance or coverage do you have? (mark all that apply)

- No coverage
- Private (Kaiser/Sutter/HMO)
- Healthy San Francisco
- Medi-Cal (Medicaid)
- Medicare
- Military
- Indian Health Services
- Other: _____
- Declined/Don't Know

HIV TESTING DETAILS

Number of HIV tests before today: _____

Date of last HIV test: _____

M	M	Y	Y
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Last test result:

- Negative
- Preliminary positive
- Positive
- Indeterminate
- Did not obtain results

If positive, reason for retest: _____

Main Reason For Testing (mark one)

- I had sex with someone who told me s/he has HIV
- I had sex with someone I think has HIV
- There was a specific sexual incident I am concerned about
- I had sex with someone who injects drugs or other substances
- I shared needles with someone who may have HIV
- I was notified by the Department of Public Health that I have been exposed to HIV
- I am starting a new relationship
- This is only a routine test
- Other: _____
- Declined/Don't Know

SEXUAL HISTORY (All questions in this section are for the past 12 months)

All sexual history declined

In the past 12 months, have you had any sex with: (mark all that apply)

	Number of partners	Sexual activity	Always protected	Unprotected* at least once
<input type="checkbox"/> Male partners	_____	<input type="checkbox"/> Oral <input type="checkbox"/> Vaginal receptive <input type="checkbox"/> Anal insertive <input type="checkbox"/> Anal receptive	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Female partners	_____	<input type="checkbox"/> Oral <input type="checkbox"/> Vaginal insertive <input type="checkbox"/> Anal insertive	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Transgender partners	_____	<input type="checkbox"/> Oral <input type="checkbox"/> Vaginal insertive <input type="checkbox"/> Vaginal receptive <input type="checkbox"/> Anal insertive <input type="checkbox"/> Anal receptive	<input type="checkbox"/>	<input type="checkbox"/>

In the past 12 months have you had protected or unprotected vaginal or anal sex with:

- Someone, in exchange for money, drugs, or any other material items
- Someone who's HIV status you did not know
- Someone you know who injects drugs or other substances
- A man you know has sex with other men (only answer this question if client is female)
- Someone who has HIV

Did you know that partner was HIV-positive before you had sex? Yes No

*The term "unprotected" refers to sex without a condom, including brief penetration without a condom. It also refers to any time a condom breaks or falls off.

SUBSTANCE USE HISTORY (All questions in this section are for the past 12 months)

All substance use history declined

In the past 12 months have you used any of these substances?

	Yes	No	Declined/Don't Know
<input type="checkbox"/> Speed (crystal, meth, tina).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Powdered cocaine.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Crack (rock).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Club drugs (e.g., ecstasy, GHB, ketamine).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Painkillers/Tranquilizers (e.g., Percocet, Oxycontin, Valium).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Five or more alcoholic drinks in a 24-hr period.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Poppers (amyl nitrate).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Viagra, Cialis, Levitra, or similar medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> None of the items listed above	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

In the past 12 months, have you injected any drugs that were not prescribed for you? Yes No

- If yes, in the past 12 months, have you: (mark all that apply)
- Shared needles or injection equipment?
 - Used a needle exchange?
 - Obtained needles at a pharmacy?

Have you ever injected any substance, including hormones or steroids? Yes (Make Hepatitis C test referral) No

STD / HEPATITIS HISTORY

In the past 12 months, have you been tested for any sexually transmitted diseases?

- Yes
- No
- Declined/Don't Know

If yes, were you diagnosed with any of the following?

- Gonorrhea
- Chlamydia
- Syphilis
- Declined/Don't Know

Have you ever been diagnosed with any of the following?

- Genital / anal warts (HPV)
- Genital herpes (HSV)
- Chronic Hepatitis B (HBV)
- Hepatitis C (HCV)

Have you been vaccinated for Hepatitis A? Yes No Don't know Have antibodies from prior infection

Have you been vaccinated for Hepatitis B? Yes No Don't know Have antibodies from prior infection