New Patient Questionnaire

Name: ______________________________________ Date: ______________________________

Date of Birth: ________________ Social Security Number: ______________________________

Address: ____

Phone Number(s): Home:____________________ Work:________________ Cell:________________

Gender: ______Male ______Female ______Transgender

What date were you diagnosed with HIV (you may give approximate date): ______________________

How did you get HIV? ____

Sexual History: Heterosexual – Yes / No Homosexual – Yes / No Bisexual – Yes / No

Sexually Active? Yes______ No ______ If yes, how many partners have you had? ______________

Sexual Practices: Vaginal – Yes / No Anal – Yes / No Oral – Yes / No

Do you use condoms or some type of barrier protection? Yes __________ No __________

Other risk factors: Have you ever been in jail? Yes __________ No __________

Have you ever had a blood infusion? __________ If yes, when? ______________________________

Have you traveled out of the country? __________ If yes, where and when? ____________________

Do you smoke? _______ If yes, at what age did you start ______ How many packs per day? ___________

Do you use street drugs? ________ If yes, what type? ______________________________________

Do you have a history of using IV drugs or any type of street drugs? ________________________

Do you drink alcohol? ________ If yes, what kind(s) ________________________ How often? __________

Do you have a history alcohol or substance abuse? ____

Do you drink coffee? _______ If yes, how many cups per day? __________

What type of diet do you follow? ____

Social History: Occupation ______________________________ Disabled? – Yes / No

Circle all that apply to you: Single Significant Other Married Legally Separated Divorced Widowed

Do you live alone? ________ If not, who do you live with? ____________________________________

Do you have any pets? ___________ If yes, what kind(s) do you have? ____________________________

Does your family know about your HIV status? ____________ If no, have you told anyone? ____________

Place of birth ______________________________

HIV Treatment history (please skip this section if you are newly diagnosed with HIV)

What is the lowest your Absolute CD4 count has been in the past? ______________________________

Please list your current HIV medications: ____

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How long have you been on the above listed HIV medications? ______________________________

Please circle any HIV medications that you were on in the past:

Sustiva efavirenz	Viramune nevirapine	Rescriptor delavirdine	Zerit stavudine (d4T)	Emtriva emtricitabine	Epivir lamivudine (3TC)	Videx didanosine (ddI)	Hivid zalcitabine
Retrovir zidovudine	Trizivir	Truvada	Epzicom	Viread tenofovir	Combivir	Ziagen abacavir	Agenerase amprenavir
Crixivan indinavir	Fortovase saquinavir	Invirase saquinavir	Kaletra lopinavir/ ritonivir	Lexiva fosamprenavir	Norvir ritonavir	Reyataz atazanavir	Viracept nelfinavir

Are you allergic to any of the HIV medications? ____________ If yes, what one(s)? ____________________

Have you had any history of HIV related opportunistic diseases? _________ If yes, please circle below:

Mycobacterium Infection	Tuberculosis	Syphilis or Neurosyphilis	Aspergillosis	Cryptococcosis	Histoplasmosis
Cryptosporidiosis	Pneumocystis Carinini Pneumonia (PCP)	Herpes Simplex lasting more than one month	Cytomegalovirus	Herpes Zoster (shingles)	Prog. Mult. Leukencephalo-pathy (PML)
Cervical Cancer	Lymphoma	Kaposi's Sarcoma	Anal Cancer	Toxoplasmosis	Non-PCP Pneumonia

Do you have any drug allergies? __________ If yes, please list ____

Please list all medications that you are currently taking (excluding HIV medications):

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Do you have any of the following symptoms?

Symptom	Yes	No	Symptom	Yes	No
Rash, itchy skin or skin disorder			Change in vision		
Sinus Congestion			Difficulty swallowing		
Hearing Loss			Dental problems		
Cough			Shortness of breath		
Fever			Night sweats		
Chest pain or palpitations			Nausea and/or vomiting		
Constipation or diarrhea			Blood in stool or hemorrhoids		
Vaginal or penile discharge			Painful urination		
Genital/rectal warts or ulcers			Muscle weakness		
Muscle pain or joint swelling			Tingling, burning, pain or numbness in extremities		
Poor appetite			Frequent headaches or migraines		
Sudden weight loss or gain					

Please list any other symptoms or health concerns you would like to discuss with your health care provider

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Does anyone in your family have any of the following problems?

Health Condition	Yes	No	Health Condition	Yes	No
Alcoholism			High Blood Pressure		
Anemia			Kidney Disease		
Bleeding Disorder			Mental Illness		
Cancer			Migraine		
Diabetes			Osteoporosis		
Epilepsy/Convulsions			Stroke		
Glaucoma			Thyroid Disease		
Hair Loss			Heart Disease		

Signature ____ Date ____________________

Vaccination History: Please list the date you last received the following immunizations if applicable:

Flu Shot ______________________ Pneumonia Vaccine ______________________

Hepatitis A Shot (s) ______________________ Hepatitis B Shot(s) ______________________

Tetanus Shot ______________________

Date of last pap smear (if applicable) ________________ Last mammogram? ________________

Date of last test for tuberculosis (PPD)? __________ Have you ever had a positive PPD test? __________

Date of last eye exam? ________________

Date of last dental exam? ______________________ Last chest x-ray? ________________

Have you ever had a colonoscopy? _________ If yes, when? ______________________

Past Medical History

Have you had any of the following sexually transmitted diseases?

	Yes	No
Syphilis		
Gonorrhea		
Venereal warts		

	Yes	No
Genital Herpes		
Chlamydia		

Do you have Hepatitis B? _____ Yes _____ No _____ Unknown

Do you have Hepatitis C? _____ Yes _____ No _____ Unknown

Have you been diagnosed with any psychological disorders? _______ If yes, please list them: ________________

____

Are you currently receiving treatment for a psychological disorder? ________ If yes, please describe treatment (i.e.: counseling, medications): ____

Are you disabled due to a psychological disorder? ____________

Have you ever tried to commit suicide? ____________________

Please list all past surgical procedures: ____

____

Please list all past in-patient hospitalizations with reason for admission: ________________________

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Do you have a history of any of the following conditions?

Medical Condition	No	Yes--Explanation
Heart Problem(s)		
Lung Problems(s)		
Diabetes		
High Cholesterol and/or Triglycerides		
Back Problems		
Joints Problems		
Neuropathy		
Seizure Disorder		
Headaches / Migraines		
Prostate or Cervical Problems		
High Blood Pressure		
Kidney Disease		
Thyroid Disease		
Anemia or Bleeding Disorder		
Cancer		