

PATIENT RISK HISTORY FORM

PART 1: FACILITY INFORMATION:

Facility Name:

PART 2: PATIENT DEMOGRAPHIC INFORMATION:

Patient Last Name	First Name	MI	DOB
			____/____/____ mm/dd/yyyy
Patient Race (check all that apply)			Hispanic Ethnicity?
<input type="checkbox"/> Black/African-American	<input type="checkbox"/> Hawaiian/Pac Islander	<input type="checkbox"/> White	(please check one)
<input type="checkbox"/> Native Amer/AK Native	<input type="checkbox"/> Asian	<input type="checkbox"/> Unknown	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
<input type="checkbox"/> Other: _____			

PART 3A: PATIENT HISTORY:

Please indicate the city and state where you were first diagnosed with HIV:	
City	State/Country
Please provide the name of the medical facility or organization where you were first diagnosed with HIV:	

PART 3B: PATIENT HISTORY CONT...

<i>Before you got diagnosed with HIV for the first time, did you: (please check a response for each line):</i>				
Have sex with a male?		Yes	No	Unknown
Have sex with a female?		Yes	No	Unknown
Inject nonprescription drugs?		Yes	No	Unknown
Receive clotting factor for hemophilia/coagulation disorder? If Yes, Please elaborate:		Yes	No	Unknown
Have sex with an intravenous/injection drug user?		Yes	No	Unknown
Have sex with a person who has hemophilia/coagulation disorder?		Yes	No	Unknown
Have sex with a transfusion recipient with documented HIV infection?		Yes	No	Unknown
Have sex with a transplant recipient with documented HIV infection?		Yes	No	Unknown
Have sex with a person with AIDS or documented HIV infection, but was not aware of how this person became infected?		Yes	No	Unknown
Receive a transfusion of blood/blood components?		Yes	No	Unknown
Receive a transplant of tissue/organs or artificial insemination?		Yes	No	Unknown
Work in a health-care or clinical laboratory setting? If yes, please specify occupation:		Yes	No	Unknown