Name_____

Are you having any symptoms? Yes No If yes, what? _____

_____

Please list any allergies to food or medicine:

_____

What medicine are you currently taking?

_____

In the past 2 weeks have you taken any medications? Yes No If yes, what? _____

_____

Please circle any STDs **<u>you</u>** have had before:
HIV hepatitis herpes gonorrhea
chlamydia trichomonas syphilis

Please circle any STDs **<u>your partner</u>** has:
HIV hepatitis herpes gonorrhea
chlamydia trichomonas syphilis

Who do you have sex with? Men Women Both

Please circle the types of sex you have: anal/"butt sex" vaginal sex oral/"blow job"/"licking"/"eating"

When was the last time you had **any** sex with **anyone**? _____/_____/_____

Number of sex partners in the last month? _____ In the last 3 months? _____

	YES	**NO**
Have you urinated/peed in the last hour?		
Have you ever used illegal/"street" drugs?		
Have you ever had sex/"hooked up" with a stranger?		
Have you had sex with more than 1 person in the last year?		
Do you know if all your sex partners (in the last year) were tested for HIV?		
Have you ever paid for sex?		
Have you ever been paid for sex?		
Have you ever traded sex for money or drugs?		
Have you ever been in jail, prison, or juvenile detention?		
Has a doctor ever told you that you have a mental illness?		
Have you ever been a victim of domestic violence?		
Have you ever been forced to have sex?		
Have you ever been/currently are homeless?		

How did you meet partners in the last year? *(check all that apply)* □Bars/clubs □Neighborhood □Work □Parks □Personal ads/phone services □Internet □Truck stop/rest areas □Through sex workers (prostitutes) □Friends/family

Do you use condoms: Never Sometimes Often Always

<u>Women only</u>:

When did your last period start? ___/____/_____

Are you pregnant? Yes No Are you breastfeeding? Yes No