Specialty Clinic
Initial History

Name of Patient: _____
Date of Birth: _____

History of Present Illness

- What was the date of your first positive HIV test? _____
- Have you ever received care for HIV? Yes No : If yes, where? _____

_____

_____

_____

Treatment Status

- What is your current CD4 (T-Cell) Count? _____
- What was your lowest CD4 (T-Cell) Count? _____
- What was your highest CD4 (T-Cell) Count? _____
- What opportunistic infection(s) have you had, if any? (PCP, MAC, Cryptococcal Meningitis, TB, etc.)

_____

_____

- What other HIV-related illnesses have you had? (Shingles, Oral Thrush, Pneumonia)

_____

_____

Active TB and TB Testing

- Have you ever had tuberculosis (TB)? Yes No
- When was your last TB test? _____ Result? _____
- Have you ever had a positive TB test? _____
  - What year and what health care setting? _____

    _____
  - What medications did you take and for how long? _____

    _____

    _____

Antiretroviral Therapy (ART)

- Are you taking HIV medications now? Yes No
- If so, please name them or describe them, and tell me how many times a day you take them?

_____

_____

_____

- How many doses have you missed in the past 3 days? _____
  - The past week? _____
  - The past month? _____
- What side effects, if any do you have now? In the past? _____

_____

_____

_____

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Antiretroviral Therapy (ART)

- What HIV medicines have you taken in the past (names or descriptions)? _____
- When did you start and stop taking them (dates)? _____
- Do you know why you stopped taking these medications? _____
- Have you ever had a resistance test? Yes ☐ No☐ Is so, please list date(s) _____

Past Medical History

Hepatitis

- Have you ever had hepatitis? What type (check all that applies)? ☐A ☐B ☐C
- Do you have chronic hepatitis? Yes ☐ No☐
- Do you know whether you are immune to hepatitis A or hepatitis B?
  - Have you been vaccinated? Yes ☐ No☐: If yes, ☐A or ☐B or ☐both

Sexually Transmitted Infections

- Have you had any of the following infections?

☐Syphilis
☐Vaginitis
☐Genital herpes
☐Nongonococcal urethritis (NGU)
☐Gonorrhea
☐Chlamydia
☐Genital Warts (HPV)
☐Anal Warts
☐Pelvic Inflammatory disease (PID)
☐Proctitis

Dental & Eye

- When was your last oral health examination? _____
- Do you have all your natural teeth? Yes ☐ No☐
- Do you have partials or dentures? Yes ☐ No☐
- When was your last vision examination? _____
- Do you wear glasses or corrective lenses? Yes ☐ No☐

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Medications

- What (non-HIV) medications do you take? Please list name and dosage below:

  _____
  _____
  _____
  _____

- What herbs, vitamins, nutritional supplements, or over-the-counter (OTC) medications, do you take? Please list name and dosage, frequency or amount: _____

  _____
  _____

Allergies; Medication Intolerance

- What, if any, medications are you allergic to? _____

  _____
  _____

- Please describe the reaction and severity of reaction. _____

  _____
  _____

- Have you had allergic reactions to any other types of exposure? If yes, please describe.

  _____
  _____

Social & Health-Related Behaviors

- Who knows about your HIV status? _____

  _____

- Do you live alone or with others? With whom? _____
- What is your relationship status (single, married, partnered, divorced, widowed? _____
- Tobacco use:
  - Do you smoke? Yes ☐ No☐ How many cigarettes per day? _____ How long have you smoked? _____ How much have you smoked in the past? _____
  - Besides tobacco, what do you smoke? _____
  - Do you chew tobacco? Yes ☐ No ☐
- Alcohol use:
  - How often do you have a drink containing alcohol? _____ How many drinks do you have on a typical day? _____ Have you ever had a problem fulfilling work, social, or school obligations because of alcohol use? Yes ☐ No ☐
- Drug use:
  - Do you use any street drugs we haven't covered in earlier questions, or drugs not prescribed to you? Yes ☐ No☐ If so, what drugs and how do you use them (inject, smoke, inhale etc.)

    _____
  - How often do you use substances? _____
  - Are you interested in treatment for alcohol or drug use? Yes ☐ No ☐

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Mental Health

- How do you handle your problems/stresses? _____
- What do you do to relax? _____
- Have you ever been diagnosed with depression, anxiety, panic, bipolar disorder, schizophrenia, etc.? Yes ☐ No☐. If yes, what? _____
- Have you taken or are you taking any mediations for these conditions? _____
- Are you seeing a therapist or mental health professional? Yes ☐ No☐ If yes, who? _____
- Have you ever been hospitalized for a psychiatric condition? Yes ☐ No☐ If yes, where? _____

Employment

- Are you currently employed? Yes ☐ No☐ If yes, where do you work? _____
- Does your employer provide health insurance? Yes ☐ No☐ What is was the date of last insurance coverage? _____
- Does your employer know of your HIV status? Yes ☐ No☐
- If on disability: How long have you been on disability? _____
  - What medical condition has made you disabled? _____

TO BE COMPLETED DURING FIRST VISIT WITH CASE MANAGER:

Additional Information & Signatures

Signature of Patient: _____ Date: _____

Signature of Case Manager: _____ Date: _____