Specialty Care Clinic-Initial History

[Place patient label here]

Today's Date: ___________________________

Date/ Approximate Year of initial positive HIV test: ____

Dates and Facilities of **Previous HIV Treatment**: ____

Drug Allergies: ____

Food Allergies: ____

Other Allergies: ____

Current Medications that you are taking:

____

____

Please list any **HIV medications** you have taken **in the past** and why you no longer take them:

____

____

Have you ever had any of the following conditions? Check all that apply. If you do not know what something is, please leave it blank.

[ ] Thrush [ ] Oral hairy leukoplakia [ ] Aphthous ulcers [ ] oral herpes [ ] esophageal candidiasis

[ ] eczema [ ] psoriasis [ ] seborrheic dermatitis [ ] toxoplasmosis [ ] peripheral neuropathy

[ ] shingles [ ] Kaposi's sarcoma [ ] pneumocystis pneumonia [ ] CMV [ ] TB (disease/infection)

[ ] mycobacterium avium complex (MAC) [ ] lymphoma [ ]chickenpox [ ] High blood pressure

[ ] mental health (please specify) ______________________ [ ] suicide attempts [ ] Diabetes type 1

[ ] Diabetes type 2 [ ] Seizures [ ] Heart Disease [ ] Emphysema/COPD [ ] Asthma [ ] GERD/ Reflux

[ ] IBS [ ] GI Ulcers [ ] Thyroid (please select type) Hypo/Hyper [ ] Hepatitis (please select type) A B C

Have you ever had any surgery? Type of Surgery? What Hospital? -

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Sexually Transmitted Infections: Please check all that apply and list the approximate date/ year that you were diagnosed.

[ ] genital/anal herpes ______________________ [ ] genital/anal warts ___________________________

[ ] Syphilis________________________________ [ ] Pelvic inflammatory disease ___________________

[ ] gonorrhea ______________________________ [ ] Chlamydia ___________________________________

[ ] Trichomoniasis _________________________ [ ] Other _______________________________________

Review of Systems: **Please circle all that apply.**

Constitutional: fever, recent weight gain or loss, appetite problems, unusual fatigue

Eyes: double vision, blurring, difficulty seeing

Ear, nose, throat: sore throat, nasal congestion, hoarse voice, hearing loss, ear pain

Cardiovascular: chest pain, palpations, extra beats, leg swelling

Respiratory: shortness of breath, wheezing/asthma, cough, bloody cough

Digestive: stomach pain, nausea, vomiting, difficulty swallowing, constipation, diarrhea, rectal bleeding

Bladder: pain with urinating, blood in urine, incontinence

GU (men only) swelling or testicular pain, penile discharge, difficulty starting stream of urine

Gynecological (women only): breast masses, vaginal discharge, vaginal pain, itching, odor

Skin/allergy: persistent rashes or hive, changes in moles, itching

Neurological: seizures, loss of balance, weakness, numbness, tremors, memory loss, headache

Psychiatric: depression, anxiety, hallucinations, difficulty sleeping, sleeping too much, suicidal thoughts

Endocrine: excessive thirst, excessive urination, heat/cold intolerance

Musculoskeletal: arthritis, back pain, joint or muscle pain, joint swelling

Blood and lymph: anemia, unusual bleeding or bruising, swollen nodes

Sleep: daytime sleepiness, fatigue, snoring, insomnia, gasping for breath while sleeping

Pregnancy/Gyn History: **[ ] Not applicable/ male**

Age at First Menstrual Cycle: ___________Age at Menopause: __________ Current Birth Control: ______________

Last Menstrual Period Start Date: ______________________ Was it: Regular [ ] Irregular [ ]

Problems with Cycle: ____

When Was Your Last Pap Smear? ____________________________ Normal [ ] Abnormal [ ]

How many times have you been pregnant? ____________

How many times have you given birth at full term? ____________ Premature? _____________

How many miscarriages have you had? ______________ Abortions? _____________

How many living children do you have? ____________________________

Were you HIV+ During Pregnancy? / On Meds? No Yes: Date___________ Hospital___________

Was Your Baby HIV+/- After Birth? Other Complications of Pregnancy: ____________________________________

Sexual History:

Ever been sexually active? Y / N   Currently sexually active? Y / N

# of partners in past 60 days ______ # of partners in the last year _______

Date of last sexual activity: __________ Partners: [ ] Male [ ] Female [ ] Other

Have your partner(s) recently been treated for a STI? Y / N   Partner symptomatic? Y / N

Sites of Exposure: [ ] Oral [ ] Vaginal [ ] Penis [ ] Anus   What percent of the time do you use condoms?___

Comments: ____

Social History: Select all that apply.

Tobacco Use [ ] How often? _______________How much? _______________How long? _______________

Recreational Drugs How often? _______________How much? _______________How long? _______________

Alcohol use [ ] H How often? _______________How much? _______________How long? _______________

Comments: ____

Support People in Your Life: ____

People Aware of Your Diagnosis: ____

Is there anything else you think we should know about your medical history or current health?

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Reviewed By: ____ Date: ___________________________