HIV RISK ASSESSMENT

Today's Date: _____ Name of Clinic:_____

First Name: _____ **Last Name**:_____ **DOB:** _____ **Age:** __

Physical Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Other Address: _____ **City:** _____ **State:**_____ **Zip:** _____

Phone: _____ **Email:** _____

Contact Restrictions: _____

Race (select all that apply): ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Other_____ ☐ Unknown

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Don't know ☐ Decline to answer

Gender at Birth: ☐ Female ☐ Male

Gender Identity: ☐ Female ☐ Male ☐ Transgender M to F ☐ Transgender F to M ☐ Genderqueer ☐ Two-Spirit

Sexual Orientation: ☐ Straight/heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Asexual ☐ Pansexual ☐ Queer ☐ Other: _____

Number of sex partners in: Last 3 months?: _____ Your lifetime?: _____ Since last tested?: _____

Where do you meet your sex partner(s): ☐ Community_____

☐ Bar(s): _____ ☐ Bath House(s): _____

☐ Category 1: Facebook/Instagram/Snapchat/Twitter ☐ Category 3: Tinder/Grindr/Scruff /AFF

☐ Category 2: Match/eHarmony/Farmer's Only/Zoosk/Plenty of Fish/Hinge/Bumble ☐ Category 4: Other

Have you ever had an HIV test?: ☐ No ☐ Yes; Result:_____ Date:_____ Location:_____

Current HIV status: ☐ Positive ☐ Negative ☐ Unknown ☐ Decline to answer

Have you had a positive STD, HIV or viral hepatitis test in the past 12 months? ☐ Yes ☐ No

If yes, specify disease and date:

Are you pregnant? ☐ Possibly ☐ Unknown ☐ No ☐ Yes, due date: _____

Symptoms (select all that apply): Onset of symptoms:_____ Duration of symptoms:_____

☐ Abdominal or pelvic pain ☐ Abnormal bleeding ☐ Abnormal penile or vaginal discharge

☐ Clay-colored stools ☐ Fever ☐ Frequent urination

☐ Night sweats ☐ Pain or bleeding with sex ☐ Pain or burning with urination

☐ Rash, generalized or on your hands/feet ☐ Penile, vaginal, or anal itching ☐ Penile, vaginal, anal, or oral lesions, sores, warts

☐ Yellowing of the skin/eyes ☐ Testicular itching ☐ Pain – perineum

☐ Other, please list:_____

Sexual History (select all that apply):

☐ Recent exposure to an STD ☐ New partner in last 3 months ☐ Polyamorous ☐ Kink/BDSM

☐ Survivor of sexual assault/abuse, past ☐ Survivor of sexual assault/abuse, current

What type/s of sexual contact have you had in your lifetime? (Select all that apply):

With a male partner(s): Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive

With a female partner(s): Anal: ☐ Give ☐ Receive Oral: ☐ Give ☐ Receive Vaginal: ☐ Give ☐ Receive

Condom use with:

Main partner(s):	☐ Always	☐ Sometimes	☐ Never
Other partner(s):	☐ Always	☐ Sometimes	☐ Never
New partner(s):	☐ Always	☐ Sometimes	☐ Never
Previous partner(s):	☐ Always	☐ Sometimes	☐ Never

Sex with (select all that apply):

☐ Anonymous partner(s) ☐ Partner(s) met on apps or the internet ☐ Pick-up(s) at bar ☐ Pick-up(s) at bath house
☐ STD+ partner(s) ☐ Hepatitis+ partner(s) ☐ HIV+ partner(s) ☐ IDU partner(s)
☐ MSM partner(s) ☐ Bisexual partner(s) ☐ Multiple partners
☐ Sex worker(s) ☐ Group sex

Sex while (select all that apply):

☐ Intoxicated ☐ High ☐ In public or semi-public place

Sex in exchange for (select all that apply):

☐ Drugs ☐ Money ☐ Food ☐ Shelter ☐ Other, please list: _____

Drug use: ☐ History of drug use ☐ Current drug use

	Method of use:					
Recreational drug(s) used:	Injection	Snorting, Snuffing (Intranasal)	Smoking	Inhaling	Ingesting (eat, drink)	Booty Bump (rectal, anal)
Cocaine						
Crack						
Opioids (heroin, fentanyl, oxycodone, etc.)						
Party drugs (ecstasy, poppers, molly, etc.)						
Erectile dysfunction medication						
Methamphetamine						
Marijuana						
Hallucinogens (LSD, psilocybin, DMT, PCP, ketamine)						
GHB						
OTC abuse (DXM, loperamide)						
Depressants (barbiturates, benzodiazepines, Ambien)						
Stimulants (Adderall, Concerta)						
Other:						

Shared works ☐ Yes ☐ No **Needle pooling** ☐ Yes ☐ No

Date of last drug use:_____

Number of partners who are/were both needle and sex partners: _____

Number of needle partners who are/were needle partners only: _____

Have you taken prescribed medication more often than prescribed? ☐ Yes ☐ No

Unprofessional/homemade tattoo(s): ☐ Yes ☐ No If yes, dates:_____

Unprofessional piercing(s): ☐ Yes ☐ No If yes dates:_____

Housing Risks:

Homelessness: ☐ History of homelessness ☐ Currently homeless
Incarceration: ☐ History of incarceration ☐ Currently incarcerated

Would you like information regarding safe sex practices and/or prevention related to any kinks/fetishes? ☐ Yes ☐ No