

FORM #1 (Forma #1)  
 Clinic # (# de Clinica) \_\_\_\_\_  
 Name (Nombre) \_\_\_\_\_  
 Date of Birth (Fecha de Nacimiento) \_\_\_\_\_  
 Time Arrived # (# de Horario de Llegada) \_\_\_\_\_

\*\* Office Use Only \*\*  
 \*Para el uso de la oficina solamente\*  
 Place Client Label Here

## SAMHD STD/HIV CLINIC INTAKE ASSESSMENT

(Para español, por favor vea el otro lado de esta hoja)

For office use only

To provide the best service to you, please answer ALL questions below.

**STAFF: Please mark all boxes and fill in the blanks that apply to the patient. Thank you.**

1.) Have you been here before?  No  Yes If yes, when was the last time? \_\_\_\_\_

- A second or third treatment (shot) for Syphilis II-R
- A second or third shot (vaccination) for Hepatitis B II-R
- A 3, 6, or 12 month follow-up blood test for Syphilis (titer check) II-R
- Staff from this clinic told you that you tested positive for Chlamydia or Gonorrhea II-R
- None of the above I

- If none of the above, then please continue completing this form by answering questions #2-5.
- If yes to any of the above, then have patient do the following: (1) if your current locating information has changed, complete form #2 and (2) take these forms up to the receptionist immediately.

2.) Did someone tell you to come in today?

- No I
- Yes, for Chlamydia or Gonorrhea II
- Yes, for Syphilis III

• If yes, then please tell us who asked you to come in:

Staff member from our clinic; Name: \_\_\_\_\_

Partner; Name: \_\_\_\_\_, DOB: \_\_\_\_\_

Other: \_\_\_\_\_

• If your partner told you to come in today, mark which infection **they** are diagnosed with:

- Chlamydia  HIV or AIDS
- Gonorrhea  Trichomoniasis
- Syphilis  Other (Please explain): \_\_\_\_\_
- I'm not sure which infection

3.) Are you having symptoms TODAY? (If yes, please check all boxes that apply & fill in blanks below.)

- No I
- Pain while urinating II
- Discharge or Drip that is (circle all that apply) clear / white / yellow / green M-II F-III
- Discharge or Drip that is bloody III
- Itching: Where? \_\_\_\_\_ III
- Rash: Where? \_\_\_\_\_ III
- Pain: Where? \_\_\_\_\_ III
- Sore(s), Lesion(s), Blister(s), Wart(s), or Bump(s) III
- Other: \_\_\_\_\_ III

4.) Is there another reason you are here TODAY?

- Testing (routine) for Sexually Transmitted Diseases or STDs (I only need to get checked) I
- Other: \_\_\_\_\_

5.) Are you here with your partner? No \_\_\_\_\_ Yes \_\_\_\_\_

(Partner's Clinic Number: \_\_\_\_\_)

Tell Patient: When the form is completed please wait for your number to be called. Thank you!