Form Approved

OMB No: 0920-XXXX

Exp. Date: XX/XX/XXXX

**Initial Patient Information Form**

Public reporting burden of this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road NE, MS D-74, Atlanta, Georgia 30333; Attn: OMB-PRA (0920-New)

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**FOR PARTNERED SITES USE ONLY**

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| **FOR PROGRAM USE ONLY** |
| **Patient information** |
| Address: |
| City: | State: | Zip code: |
| Phone number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | □ home | □ mobile |
| Phone number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ | □ home | □ mobile |
|  Email address: |
| **Clinic information** |
| Provider name: |
| Clinic name: | Clinic phone number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Clinic fax number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Primary clinic contact person: | Contact phone number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Email address: |
| Secondary clinic contact person: | Contact phone number: (\_\_\_\_) \_\_\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Email address: |

**-------------------------------------------------------------------------------------------------------------------------------**

**Date:** \_\_\_/\_\_\_/\_\_\_\_

**Initial Patient Information Form**

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| **I. Patient Demographic Information** |
| **Date of Birth (month/year)** | \_\_\_\_\_/ \_\_\_\_\_\_ |
| **Sex: (check all that apply)** |
| □ Male | □ Female | □ Transgender |
| **Race (check all that apply)** |
| □ White | □ Black/African American | □ Asian | □ Native Hawaiian/Pacific Islander | □ American Indian/Alaska Native | □ Other: \_\_\_\_\_\_\_\_\_\_ |
| **Ethnicity** |
| □ Hispanic/Latino | □ Not Hispanic/Latino | □ Unknown |
| **Education level** |
| □ less than high school | □ high school only | □ some college | □ college or above | □ Unknown |
| **Number of people in household:** \_\_\_\_\_\_\_\_\_ □ Unknown |
| **Annual household income** |
| □ < $15,000 | □ ≥ $15,000 - < $30,000 | □ ≥ $30,000 | □ Unknown |
| **Housing status** |
| □ currently homeless | □ not currently, but homeless in the past 12 months | □ homeless previously, but not homeless in the past 12 months | □ Never homeless | □ Unknown |
| **Employment status** **(check all that apply)** |
| □ unemployed | □ employed  | □ disabled | □ student | □ retired | □ Unknown |
| **If patient is employed, is he/she employed part time or full time?**  |
| □ N/A | □ part time | □ full time | □ Unknown |
| **Medical Insurance status (check all that apply)** |
| □ Private insurance | □ Medicaid | □ Medicare | □ Ryan White/ADAP | □ uninsured | □ Unknown |

Date of patient’s first visit to *THIS* clinic:\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY)

*All dates should be in the MM/DD/YYYY format*

|  |
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| **II. Diagnosis Information** |

**Date of HIV Diagnosis: ­­­**\_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_\_ (MM/DD/YYYY) □ Unknown

**Disease Stage at diagnosis:** □ stage 1 HIV □ stage 2 HIV □ stage 3 AIDS □ stage Unknown □ Unknown

**Date first entered into care for HIV:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ □ Unknown

\*enter the date the patient first entered into HIV care which might not be the date the patient first entered into care at thisclinic

|  |
| --- |
| **III. Patient Laboratory Information and Vital signs** |

**A. Please provide the following information:**

Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ (inches) Date: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

 Most recent weight: \_\_\_\_\_\_\_\_\_\_\_\_\_\_(lbs/kg (circle)) Date: \_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_

**B. Please provide patient’s blood pressure values for the *past 12 months***

 Blood pressure: \_\_\_/\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

 Blood pressure: \_\_\_/\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

 Blood pressure: \_\_\_/\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

 Blood pressure: \_\_\_/\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_\_

**C. Please provide the following laboratory values for the *past 24 months***

*Please use the additional tables at the end of the form if there are more than four lab values over the past 12 months*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Laboratory Test** | **Value/Date** | **Value/Date** | **Value/Date** | **Value/Date** |
| **CD4** **(cells/ µL and %)** |  \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ |
| **HIV-1 RNA/DNA NAAT (Quantitative viral load)****(copies/mL)** | Copies/mL: \_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | Copies/mL \_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  | Copies/mL \_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  | Copies/mL \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  |

**D. Please provide the following laboratory values for the** ***past 12 months***:

*Please use the additional tables at the end of the form if there are more than four lab values over the past 12 months*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Laboratory Test/Screenings** | **Value/Date** | **Value/Date** | **Value / Date** | **Value/Date** |
| **Total Cholesterol****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **LDL:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HDL:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **TG:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HbA1c** (only if diagnosed with diabetes):  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Glucose:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Hemoglobin:**  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |
| **LFTs****(units/L)**  | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ |
| **Bilirubin****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Creatinine**   |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Urinalysis**  | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ |
| **Was a basic chemistry** **panel completed?** | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ |
| **HBV DNA** **(if HBV co-infected)****(copies/mL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HCV RNA****(if HCV co-infected)****(copies/mL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Syphilis screening**  | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ |

Y = yes

N = no

UNK = Unknown

**E. Please provide the following information on viral hepatitis testing**

|  |
| --- |
| **Viral Hepatitis** |
| **Has the patient ever been tested for HBsAg\*?**  | □ yes | □ no | □ Unknown |
|  | If yes, results: | □ negative | □ positive |
| **Has the patient ever been tested for anti-HBs^?** | □ yes | □ no | □ Unknown |
|  | If yes, results: | □ >10 mIU/mL | □ < 10 mIU/mL |
| **Has the patient ever been tested for anti-HCVǂ?** | □ yes | □ no | □ Unknown |
|  | If yes, results: | □ negative | □ positive |
| **If anti-HCV test was positive, was a confirmatory test done?**  | □ yes | □ no | □ Unknown |
|  | If yes, results: | □ negative | □ positive |

\*HBsAg = hepatitis B surface antigen

^Anti-HBs = antibody to the hepatitis B surface antigen

**ǂ**Anti-HCV = antibody to hepatitis C virus

|  |
| --- |
| **IV. Immunizationsǂ** |
| **Vaccine** | **Vaccination Received Ever** | **Number of doses** | **Dates** | **Series completed?** |
| **Hepatitis A** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | **□** yes□ no□ Unknown |
| **Hepatitis B** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | **□** yes□ no□ Unknown |
| **Hepatitis A/B** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | **□** yes□ no□ Unknown |
| **Human papilloma virus** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | **□** yes□ no□ Unknown |
| **Pneumococcal‡** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ |  |
| **Influenza** | □ yes□ no□ Unknown |  | \_\_\_/\_\_\_/\_\_\_\_(most recent dose) |  |
| **Meningococcal‡** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ |  |
| **Tetanus (Td)** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_(most recent dose) |  |
| **Tetanus, diphtheria, pertussis (Tdap)** | □ yes□ no□ Unknown | \_\_\_\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |  |

 ǂ please list all immunizations ever received

 ‡includes both the conjugate and polysaccharide vaccines

|  |
| --- |
| **V. Medication Use** |

**A. Has patient ever taken antiretroviral therapy (ART)? □ yes □ no**

 **If yes, what was the date of first *ever* ART\*:** \_\_\_\_/\_\_\_\_/\_\_\_\_\_ **□ N/A □ Unknown**

 \*please list the date first started on ART, which may not be the date the patient started on ART at *this* clinic

 **Is patient currently taking ART?** **□ yes □ no**

 **If no, date of last use:** \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ **□ N/A □ Unknown**

**Has an HLA-B\*5701 test been done?**  □ yes □ no

 If yes, what was the result of the HLA-B\*5701 test? □ negative □ positive

**Has a tropism assay been done?** □ yes □ no

 If yes, what were the results?

 □ CCR5 positive □ CXCR4 positive □ dual or mixed tropism

**B. Current ART Medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Current ART Medications\*** | **Dosage (mg)** | **Frequency** | **Start date** |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |

\*Fixed dose combination medications (e.g. Atripla) should be listed on one line

**C. Please provide a list of ALL former ART medications ever taken**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of ALL Former ART Medications ever taken** | **Dosage (mg)** | **Frequency** | **Start date** | **Date discontinued** | **Reason for discontinuation** |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ | □ tolerability □ toxicity / side effects□ failure □ other \_\_\_\_\_\_\_\_\_\_\_ |

 **D.** **List all medications that patient is currently taking for opportunistic infection (OI) treatment or prevention**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Name of Current Medication for OIs** | **Name of OI** | **Dosage (mg)** | **Frequency** | **Start date** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |

**E. List all medications that patient has formerly taken for opportunistic infection (OI) treatment or prevention over the *past 24 months***

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Name of Former Medication for OIs** | **Name of OI** | **Dosage (mg)** | **Frequency** | **Start date** | **Date Discontinued** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |
|  |  |  |  | \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_/\_\_\_/\_\_\_\_ |
| **□ treatment****□ prophylaxis** |

**F. List other CURRENT medications**

|  |  |  |  |
| --- | --- | --- | --- |
| **Names of Other Current Medications** | **Dosage (mg)** | **Frequency** | **Start date** |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |
|  |  |  | \_\_\_/\_\_\_/\_\_\_\_ |

|  |
| --- |
| **VI. Current Medical History and Allergies** |

**G. Please list all current medical problems including mental illnesses**

|  |
| --- |
| **Current Medical Problem List†** |
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|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |
|  |

†please list each mental health diagnosis separately

**H. Please list all known drug allergies**

 **If patient has no known drug allergies please check the following box:** □ no known drug allergies

|  |  |
| --- | --- |
| **Name of medication** | **Reaction to medication** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| **VII.** **Tobacco, Drug and Alcohol use** |
| **Is the patient a smoker?**  | □ yes | □ no | □ no, but past use | □ Unknown |
| **If patient is a former smoker, how long ago did patient quit?** | Years: \_\_\_\_\_\_ | Months: \_\_\_\_\_ | □ Unknown |
| **If patient is a *present* or *past* smoker, what is the pack year smoked?** Number of pack years = (packs smoked per day) × (years as a smoker) | \_\_\_\_\_\_\_\_\_\_\_ | □ N/A |
| **Does the patient use illegal drugs or abuse prescription controlled substances?**  |
| Injection drug use  | □ yes | □ no | □ no, but past use | □ Unknown |
| Non-injection drug use | □ yes | □ no | □ no, but past use | □ Unknown |
| **Is patient currently or has patient ever been in a substance abuse treatment program?**  |
| □ N/A | □ yes, currently in a program | □ yes, in the past | □ no | □ Unknown |
| **If patient has ever been in a substance abuse treatment program, did patient complete the program?** |
| □ N/A | □ yes | □ no | □ Unknown |
| **Does the patient drink alcohol heavily?**Heavy alcohol consumption for males equals ≥5 drinks on any single day or ≥15 drinks per week; for women heavy alcohol consumption equals ≥4 drinks on any single day or ≥8 drinks per week |
| □ yes | □ no | □ no, but past use | □ Unknown |
| **If patient is a former heavy drinker, how long has patient been abstinent?** | □ N/A | Years: \_\_\_\_\_\_ | Months: \_\_\_\_\_\_ | □ Unknown |
| **Is patient currently or has patient ever been in an alcohol abuse treatment program?**  |
| □ N/A | □ yes, currently in a program | □ yes, in the past | □ no | □ Unknown |
| **If patient has ever been in an alcohol abuse treatment program, did they complete the program?** |
| □ N/A | □ yes | □ no | □ Unknown |

|  |
| --- |
| **VIII. Clinic Appointment Information** |

**Is patient new to this clinic or new to HIV care?** □ yes □ no

**Please list ALL appointments (medical, case management, mental health, substance abuse) scheduled for the patient in the past 24 months and note if appointment was kept.**

**Include only one appointment type and date in each box**

|  |  |
| --- | --- |
| Type of appointment Date Was appt. kept? | Type of appointment Date Was appt. kept? |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |

\*a medical appointment with a physician, nurse practitioner or physician’s assistant

†appointment with Case management or a Social Worker

|  |
| --- |
| **IX. Follow-up** |

**When is patient’s next scheduled medical visit (with a physician, nurse practitioner or physician’s assistant)?**

date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ □ no appointment scheduled

**When is patient’s first scheduled MTM appointment?**

date: \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_ □ no appointment scheduled

**NOTES: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDITIONAL LABORATORY TEST VALUES**

(use if there are more than four laboratory values in the past 12 to 24 months)

**Please provide the following laboratory values for the *past 24 months***

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Laboratory Test** | **Value/Date** | **Value/Date** | **Value/Date** | **Value/Date** |
| **CD4** **(cells/ µL and %)** |  \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_ cells/µL \_\_\_\_\_ % \_\_\_/\_\_\_/\_\_\_\_ |
| **HIV-1 RNA/DNA NAAT (Quantitative viral load)****(copies/mL)** | Copies/mL: \_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | Copies/mL \_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  | Copies/mL \_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  | Copies/mL \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_  |

**Please provide the following laboratory values for the** ***past 12 months***:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Laboratory Test/Screenings** | **Value/Date** | **Value/Date** | **Value / Date** | **Value/Date** |
| **Total Cholesterol****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **LDL:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HDL:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **TG:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HbA1c** (only if diagnosed with diabetes):  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Glucose:****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Hemoglobin:**  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |  \_\_\_\_\_\_\_\_  |
| **LFTs****(units/L)**  | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ | ALT \_\_\_\_\_\_\_AST \_\_\_\_\_\_\_\_\_\_/\_\_\_/\_\_\_\_ |
| **Bilirubin****(mg/dL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Creatinine**   |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |  \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Urinalysis**  | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ | + protein- protein\_\_\_/\_\_\_/\_\_\_\_ |
| **Was a basic chemistry** **panel completed?** | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ | Y / N\_\_\_/\_\_\_/\_\_\_\_ |
| **HBV DNA** **(if HBV co-infected)****(copies/mL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **HCV RNA****(if HCV co-infected)****(copies/mL)**  | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ | \_\_\_\_\_\_\_\_ \_\_\_/\_\_\_/\_\_\_\_ |
| **Syphilis screening**  | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ | □ negative □ positive \_\_\_/\_\_\_/\_\_\_\_ |

**ADDITIONAL CLINIC APPOINTMENT INFORMATION**

(use if use if needed to record clinic appointment information

|  |  |
| --- | --- |
| Type of appointment Date Was appt. kept? | Type of appointment Date Was appt. kept? |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
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| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
| Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ | Medical visit\* □ \_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ □ yes □ no Case management† □ □ Unknown Mental Health □ Substance Abuse □ |
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\*a medical appointment with a physician, nurse practitioner or physician’s assistant

†appointment with Case management or a Social Worker