Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Form Approved
OMB No: 0920-XXXX
Exp. Date: XX/XX/XXXX

Initial Patient Information Form

FOR PARTNERED SITES USE ONLY

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: ___/___/____

Patient Project ID: _____
Staff Project ID: _____
Clinic Project ID: _____

Initial Patient Information Form

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

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 this clinic

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 _____	ALT _____	ALT _____	ALT _____

	AST _____ ___/___/____	AST _____ ___/___/____	AST _____ ___/___/____	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-HCV‡?	□ 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
‡Anti-HCV = antibody to hepatitis C virus

IV. Immunizations‡				
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	_____	___/___/____	

‡ 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**			___/___/____

Patient Project ID: ___________
Staff Project ID: ___________
Clinic Project ID: ___________

	☐ 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†

†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* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown

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 ___/___/____

Patient Project ID: ___________
Staff Project ID: ___________
Clinic Project ID: ___________

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* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown
Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown	Medical visit* ◻ Case management† ◻ Mental Health ◻ Substance Abuse ◻	____/_____/_____	◻ yes ◻ no ◻ Unknown

*a medical appointment with a physician, nurse practitioner or physician's assistant
†appointment with Case management or a Social Worker