HIV Patient Questionnaire

DATE: _____

NAME_____ **DATE OF BIRTH** _____
Last First Middle Mo Day Yr.

Referred By: _____Reason for visit_____

When was your HIV infection diagnosed? _____

PAST MEDICAL HISTORY: Conditions for which you have seen a Doctor, including psychiatric. Circle those that apply, or list conditions for which you are being treated.

Diabetes	High Blood Pressure	Heart Disease	Stroke	Gout	TB	Hepatitis
Cancer	Jaundice	Urinary Tract Infections		Kidney Stones		Depression
Seizures	Pneumonia	Asthma	HIV Infection		Thyroid Conditions	
High Cholesterol						

_____

_____

Hospitalization(s) Including Psychiatric

_____Year_____ _____Year_____

_____Year_____ _____Year_____

Please list all prescription or over the counter medications, herbs, supplements, or vitamins you are NOW taking:

_____ _____ _____

_____ _____ _____

Please list previous HIV medications_____ _____

_____ _____ _____

Pharmacy: _____Phone #_____

List any drug allergies or reactions you have had:

Drug _____ Reaction_____

Drug _____ Reaction_____

Family History (Cancer, heart disease, Diabetes, TB etc.)(If deceased cause of death):

Father _____

Mother _____

Brothers/ Sisters _____

Children _____

Did you receive all of your childhood vaccines? Y N Unknown

When was the last time (Year) you had a

Flu vaccine	_____	Dental exam	_____
Pneumococcal vaccine	_____	Eye exam	_____
Hepatitis B vaccine	_____		
Hepatitis A vaccine	_____	Pap smear	_____
Tetanus vaccine	_____	Mammogram	_____
HPV (Papilloma Virus Vaccine)	_____	Colonoscopy	_____
Varicella(Chicken pox) Vaccine	_____		

Have you had chicken pox: Y N Unknown

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FOR WOMEN ONLY:

Number of Pregnancies _____ Number of Births _____
Could you be pregnant? Y N
Are you interested in becoming pregnant in the future? Y N

SOCIAL HISTORY:

Primary language spoken: _____
Country of Birth: _____
If you were born outside the United States, what year did you move to United States? _____
If born outside the US, what year did you last visit your country of origin? _____
Highest Level of Education: _____
Occupation: _____
Military Service: Y N Stationed overseas? Y N If yes, where? _____
Current Marital Status: Married Partner Single Separated Divorced Widowed Unknown
Number of Children? _____
Who lives with you: _____
What type of home do you live in? _____
Which tobacco products have you used (Circle all that apply)?
Chewing Cigar Cigarettes Pipe Smokeless
Number of years? _____
When did you last use a tobacco product? Year _____
Have you consumed alcohol: Y N
Type of Alcohol (Circle all that apply): Beer Hard Liquor Moonshine Wine
Drinks per week? _____
When was your last alcoholic drink? Year ____
Do you (circle all that apply):
Camp Fish Garden Golf Hike Hunt Jog Swim in lakes/ponds
Do you eat any of the following (circle all that apply)?
Raw Oysters Sushi Unpasteurized Dairy Products
Are you exposed to any animals? Y N Type: _____
Do you clean up after the animals? Y N
What is your religious affiliation (Circle)?
Christian Hindu Islam Jewish Jehovah's Witness Other _____ None
Does your home have (Circle)?: Well Water City Water
What Countries have you visited? _____

Have you ever:

received a blood transfusion?	Y	N	Year _____
donated blood?	Y	N	Year _____
had hepatitis?	Y	N	
been exposed to tuberculosis / TB?	Y	N	
Agree to blood transfusion if needed?	Y	N	

Have you had any legal problems related to alcohol such as DUI? Y N
Have you ever used street drugs: Y N
Type (Circle all that apply):
Amphetamines Barbiturates Cocaine Crack Ecstasy Heroin Inhalants LSD Marijuana
Morphine Opium PCP Speed Vicodin Other _____
Route of drug use (Circle all that apply): Intramuscular Inhaled Intravenous By Mouth Snorted
If you have injected drugs, how often do you borrow or share a needle or works (Cricle)?
Always Sometimes Never
Have you been referred to a substance abuse treatment program? Y N
When was that last time you used street drugs? Year _____

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Do you have a psychiatric history? Y N
Type (Cirlce all that apply) Anxiety Bipolar Disorder Depression Eating Disorder
Gender Identity Disorder Obsessive-Compulsive Disorder Panic Attacks
Posttraumatic Stress Disorder Schizophrenia
Have you ever been in prison, workhouse, or jail? Y N
Do you think of yourself as heterosexual (straight), homosexual (gay), or bisexual (bi)? _____
Have you ever had a homosexual contact? Y N
How many sexual partners have you had during your lifetime? _____
How often do you use condom when you have sex? Always Sometimes Never
Have you had a sexually transmitted disease? Y N
Type of sexually transmitted disease (Circle all that apply):
Bacterial vaginosis Chancroid Chlamydia Clap Crabs/Lice Drip Genital warts Gonorrhea
Hepatitis B Hepatitis C Herpes Human Papilloma Virus Syphilis Trichomonas
Have all of your sex or needle sharing partners been informed of their exposure to HIV? Y N
Any new sex or needle sharing partners? Y N
What type of birth control do you use (Circle all that apply)?
None Abstinence Condoms Birth Control Pills/Patch Female Condom
Hysterectomy IUD Post Menopausal Rhythm Spermicide Tubal Ligation
Vasectomy
Route of HIV Transmission (Circle most likely route):
Male sex with Male - homosexual
Injected non prescription drugs
Received clotting factor Type ___
Transfusion Mo __ Yr _____
Received transplant Artificial insemination
Worked in health care or clinical lab (specify occupation: _____)
Heterosexual relations with (circle all that apply): Intravenous drug abuser Bisexual male
Person with hemophilia Transfusion or transplant recipient with HIV
Person with AIDS or documented HIV
Do you have a Living Will/ Advanced Directive in place? Y N
Does Raleigh Infectious Diseases have a copy of your Living Will/Advanced Directive Y N
Have you designated a Medical Power of Attorney Y N
If yes, Name _____ Relationship _____
Telephone Number (_____) _____ - _____
Does Raleigh Infectious Diseases have a copy of your Medical Power of Attorney ? Y N

If you are on antiretroviral therapy, estimate the number of doses that you have missed in the last
month.___
week ___

Who Knows about your HIV? _____

HIV Patient Questionnaire

NAME_____

SYSTEM REVIEW: Please CIRCLE any problems that you are NOW experiencing.
CONSTITUTIONAL: fever, sweats, appetite/weight change, fatigue, weakness, changes in sleep
SKIN: itching, rash, warts, hair changes, nonhealing skin problems
EYES: blurred vision, double vision, glaucoma
EARS, NOSE, THROAT: ringing in your ears, hearing loss, vertigo, sinus infection, seasonal allergies, recurrent Strep throat, bloody nose, runny nose
CARDIOVASCULAR: chest pain, fainting, heart murmur, high blood pressure, leg swelling, phlebitis, shortness of breath, irregular heart rhythm, rheumatic fever
RESPIRATORY: cough, cough up blood, bronchitis, pneumonia, wheezing, asthma
GASTROINTESTINAL: constipation, diarrhea, indigestion, abdominal pain, nausea, vomiting, swallowing difficulty, diverticulitis, polyps, hemorrhoids, ulcers, liver disease, gall bladder disease, pancreatitis, reflux, heartburn
GENITOURINARY: burning, dribbling, frequency, hesitancy, incontinence, urgency, blood in urine, recurrent infection, kidney stones
MUSCULOSKELETAL: arthritis, joint swelling, muscular pain, muscle weakness
NEUROLOGICAL: dizziness, fainting, headaches, bowel or bladder incontinence, memory impairment, numbness, seizures, speech difficulties, tremor, weakness
PSYCHIATRIC: anxious, depressed, sleeping difficulties, history of counseling
HEMATOLOGIC/LYMPHATIC: anemia, sickle cell disease, swollen lymph nodes, easy bruising or bleeding
ALLERGIC/IMMUNOLOGIC: allergies, asthma, rash
ENDOCRINE: diabetes, thyroid disease

Completed by:_____ Date:_____

Reviewed by: _____ Date:_____

Raleigh Infectious Diseases Associates

2304 Wesvill Court
Raleigh, NC 27607-2973
(919) 571-1567

PATIENT INFORMATION

NAME (Last, First Middle)	MRN	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	REFERRING PHYSICIAN	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	PRIMARY CARE PROVIDER	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	EMERGENCY CONTACT NAME	CONTACT PHONE HOME PHONE
	☐ Full-Time ☐ Part-Time				

PRIMARY EMPLOYER	SECONDARY EMPLOYER (if Applicable)
ADDRESS	ADDRESS
CITY, STATE ZIP	CITY, STATE ZIP
WORK PHONE	WORK PHONE

RESPONSIBLE PARTY INFORMATION (if Different than above)

NAME (Last, First Middle)	SSN#	BIRTHDATE	LANGUAGE	SEX

LOCAL ADDRESS	CITY, STATE ZIP	SECONDARY/BILLING ADDRESS (if Applicable)

HOME PHONE	DAY PHONE	EMAIL ADDRESS	CITY, STATE ZIP

MARITAL STATUS	STUDENT STATUS	SMOKER (Y/N)?	VETERAN (Y/N)?	PRIMARY CARE PROVIDER	HOME PHONE
	☐ Full-time ☐ Part-time				

RELATIONSHIP TO PATIENT	

PRIMARY INSURANCE

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

SECONDARY INSURANCE (if Applicable)

NAME OF INSURANCE COMPANY	POLICY#
NAME OF INSURED	GROUP#
ADDRESS OF INSURANCE COMPANY	COPAY AMT $
CITY, STATE ZIP / PHONE	DEDUCTIBLE $
RELATIONSHIP TO PATIENT	EFFECTIVE DATE / EXPIRATION DATE

I hereby release my insurance benefits to be paid directly to the physicians at Raleigh Infectious Diseases Associates . I hereby authorize the release of pertinent medical information to my insurance carriers and to healthcare providers deemed necessary to participate in my care. I understand and agree that, regardless of my insurance status, I am ultimately financially responsible for the balance of my account for any professional services rendered.

SIGNATURE OF PATIENT/GUARDIAN _____ DATE _____

Raleigh Infectious Diseases Associates, PA
Acknowledgement of Notice of Privacy Practices

Name _____ **DOB** _____

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information (PHI) about you. You have the right to review our notice before signing this consent. As provided in our notice, the terms of this notice may change. If we change our notice, you may obtain a revised copy by requesting one at your next appointment or contacting our Privacy Officer. You have the right to request restrictions as to how PHI about you is used or disclosed for treatment, payment and health care operations. Any special requests will be reviewed and addressed. We are not required to agree to this restriction. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

By signing this form, you consent to our use and disclosure of protected health information for the purposes of treatment, payment and health care operations. Sharing of PHI may include release of information to other physicians, institution or healthcare agency as necessary to provide treatment or diagnosis. This may include sensitive information such as HIV status and mental health information. We will also share information in order to process insurance or worker's comp claims and to facilitate payment for services.

Acknowledgement of Ways in Which You May Be Contacted

In order to contact you regarding treatment, payment and health care operations, we would like for you to be aware of ways in which you may be contacted. You may be contacted through the work, home, and mobile phone numbers. Our staff may leave discreet messages on your answering machine, voice mail, or with others. Appointment reminders, account statements, and medical correspondence will be mailed to your home address, as well as other information that is critical to our treatment, payment and healthcare operation. We may not release information to family members, spouses, legal representatives without specific written consent as indicated below.

Please list all phone numbers and indicate your 1ST and 2nd preference by checking the corresponding box.

☐ **Home phone**_____

☐ **Work phone** _____

☐ **Cell phone** _____

Please list one family member or other representative with whom we may discuss your healthcare and/or billing information:

Name: _____**Relationship:**_____

Phone : _____

Other specific request:_____

_____

_____

_____ _____

Signature **Date**