## COMMUNICABLE DISEASE RISK ASSESSMENT

**DATE OF VISIT:**_________________________

**Client:** Please fill out these two pages. This will help your provider select the right tests or vaccinations for you.

**DEMOGRAPHICS**

**Patient Name:** ______________________________________________________ **DOB:** ____________ **Age:** __________
**Address:** __________________________________________ **City:** _____________________________ **Zip:** ____________
**Phone:** ____________________ Email: ________________________________________________________________
**How should we contact you?** ☐ Phone ☐ Email ☐ Mail ☐Other: ___________________________________________
**What is your monthly income?** ____________________ **How many people are supported by that income?** ___________
**Contact Restrictions:** ________ **Medicaid:** ☐ **Insurance:** ☐ **No Insurance:** ☐ **Insurance Doesn't Cover** ☐

**How did you hear about us?**
☐ Knowyo.org ☐ Poster ☐ Word of mouth ☐ Radio ☐ Billboard ☐ Newspaper ☐ WDH staff ☐ Other _________________

**Race** (select all that apply): ☐ White ☐ Black/African American ☐ American Indian/Alaska Native ☐ Asian ☐ Native Hawaiian/Pacific Islander ☐ Other ☐ Don't know ☐ Decline to answer
**Ethnicity:** ☐ Hispanic ☐ Non-Hispanic ☐ Don't know ☐ Decline to answer
**Marital status:** ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

**Sex at birth:** ☐ Female ☐ Male **Gender identity:** ☐ Female ☐ Male ☐ Transgender Female ☐ Transgender Male ☐ Genderqueer, neither male nor female ☐ Other
**Sexual orientation:** ☐ Straight/heterosexual ☐ Lesbian or gay ☐ Bisexual ☐ Pansexual ☐ Don't know ☐ Other

**SEXUAL HEALTH AND HISTORY**

Do you have sex with (select all that apply): ☐ Females ☐ Males ☐ Other, please list:________________________
How many sex partners have you had in the last 3 months? ________________In the last 12 months? ________________
What type of sex are you having? (select all that apply)
☐ Oral ☐ Giving partner ☐ Receiving partner
☐ Vaginal
☐ Anal ☐ Receptive partner ☐ Insertive partner

Have you ever had an HIV test? ☐ Yes, result and date: ________________________________________________ ☐ No

Do you know if you have recently been exposed to any STDs, HIV or viral hepatitis? ☐ Yes ☐ No ☐ Unknown
If yes, specify disease and date:__________________________________________________________________________
Contact type: ☐ Household ☐ Sexual ☐ Needle-sharing ☐ Blood exposure
Have you had a positive STD, HIV or viral hepatitis test in the past 12 months? ☐ Yes ☐ No
If yes, specify disease and date:__________________________________________________________________________

Do you want to have a baby in the next year? ☐Yes☐ No
Do you want to have children? ☐Yes ☐ No If yes, when? __________-______________
If you are trying to prevent a pregnancy, what method are you using? _________________________
Are you pleased with this method? ☐ Yes☐ No
**Females Only:**
Are you pregnant? ☐No ☐Unknown Yes, due date: _______ Date of last pelvic exam/pap test: _____________☐ Unknown
Last mammogram:_________________ First Day of Last Menstrual Period:________________

**Condom Use**
Condom use with new partner: ☐ Always ☐ Sometimes ☐ Never
Condom use with main partner: ☐ Always ☐ Sometimes ☐ Never
Condom use with other partners: ☐ Always ☐ Sometimes ☐ Never

## Please select boxes pertaining to you (select all that apply)

**Sex with:**
- ☐ Anonymous partners
- ☐ Partners met on apps or the internet
- ☐ More than one partner at a time (Group Sex)

**Sex while:**
- ☐ Intoxicated
- ☐ High
- ☐ In public

**Sex in exchange for:**
- ☐ Drugs
- ☐ Money
- ☐ Food
- ☐ Shelter
- ☐ Other, please list:_____________

**History of:**
- ☐ Prior STDs or viral hepatitis
- ☐ HIV infection
- ☐ Consistently abnormal liver tests
- ☐ Immunosuppressive therapy
- ☐ Dialysis
- ☐ Working in a healthcare setting
- ☐ Blood exposure (under skin or mucous membranes)
- ☐ Blood transfusion, blood components, or organ transplant (prior to 1992)
- ☐ Recipient of clotting factor or blood concentrations (prior to 1987)
- ☐ Vaccines received:
  - ☐ Hepatitis B
  - ☐ Hepatitis A
  - ☐ HPV

**Homelessness:**
- ☐ History of homelessness
- ☐ Currently homeless

**Baby Boomer:**
- ☐ Born between 1945-1965

**Incarceration:**
- ☐ History of incarceration
- ☐ Currently incarcerated

**Tattoos or piercings:**
- ☐ Unprofessional/at-home tattoos
- ☐ Unprofessional/at-home piercings

**Born outside U.S.:**

| Client: | Parent: |
|---|---|
| ☐ Africa | ☐ Africa |
| ☐ Asia | ☐ Asia |
| ☐ South America | ☐South America |
| ☐ Mexico | ☐ Mexico |
| ☐ Central America | ☐Central America |

**Illicit drug use:**

Injection drug use (heroin, fentanyl, etc.)
☐ Current ☐ Past

Intranasal drug use (meth, cocaine, etc.)
☐ Current ☐ Past

Other drug use (marijuana, LSD, etc.)
☐ Current ☐ Past

**Mother – history of:**
- ☐ HIV
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ STDs

**Intimate partner and family violence**
- ☐ Are you a survivor of sexual assault?
- ☐ Have you ever been hit, slapped, kicked, strangled, shaken or hurt by anyone?
- ☐ Is there anyone who makes you feel unsafe?
- ☐ Have you ever been forced or coerced to do anything sexual?

**Symptoms (select all that apply):**
- ☐ 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
- ☐ Penile, vaginal, or anal itching
- ☐ Penile, vaginal, anal, or oral lesions, sores, or warts
- ☐ Rash, generalized or on your hands/feet
  List:__________________
- ☐ Yellowing of the skin (jaundice)
- ☐ Other, please list:____________________