

**DEWITT-PIATT BI-COUNTY HEALTH DEPARTMENT**  
**Female Risk Assessment & Contact Treatment without an Examination**

Name \_\_\_\_\_ Date \_\_\_\_\_ Chart # \_\_\_\_\_

I am requesting treatment for \_\_\_\_\_ based on the fact that my partner has been found to be infected.

*We have tried to make this form as complete as possible; realizing that some questions will not apply to everyone's particular circumstances. All information is strictly confidential.*

**MENSTRUAL, PREGNANCY & CONTRACEPTIVE HISTORY** Date Your Last Period started: \_\_\_\_\_

YES	NO		Yes	No	
___	___	Was your last period normal and on time?	___	___	Have you had intercourse since your last period?
___	___	Could you be pregnant now?	___	___	Are you breastfeeding now?
___	___	Do you or your partner use birth control now?			
		If yes, what method(s) do you use? _____			How long have you used this method? _____

**SEXUAL HISTORY**

How many partners in the past 90 days? \_\_\_\_\_ How long with current partner? \_\_\_\_\_ Date of last exposure \_\_\_\_\_  
Type of Sex: \_\_\_ vaginal \_\_\_ anal \_\_\_ oral \_\_\_ other Are your partner(s): \_\_\_ male \_\_\_ female \_\_\_ both  
Yes No  
\_\_\_ \_\_\_ Do you use condoms for protection against sexually transmitted diseases? \_\_\_ always \_\_\_ sometimes \_\_\_ never  
\_\_\_ \_\_\_ Have you ever had a sexually transmitted disease? List: \_\_\_\_\_  
\_\_\_ \_\_\_ Have you ever been tested for HIV?  
\_\_\_ \_\_\_ Have you ever had sex with someone who has been incarcerated?  
\_\_\_ \_\_\_ Have you ever had sex while ðhighö or drunk?  
\_\_\_ \_\_\_ Are you in a relationship where you are being forced to have sexual relations?  
\_\_\_ \_\_\_ Have you had sex with someone you do not know (anonymous)?  
\_\_\_ \_\_\_ Have you had sex with someone you met over the internet?

**SOCIAL/HEALTH RISK HISTORY**

Yes	No	
___	___	Do you smoke? How many cigarettes daily? _____ How long have you smoked? _____
___	___	Do you use alcohol? Number of drinks per day _____ per week _____ per month _____ per year _____
___	___	Do you or your partner(s) use street or IV (injectable) drugs? If so, list _____
___	___	Have you or your partner(s) ever shared needles of any kind (piercing, tattooing, drugs)?

**ALLERGIES:** Please list any allergies, including **Latex**, drugs, skin allergies or irritants.

**PAST MEDICAL HISTORY**

Have you ever had surgery or been a patient in a hospital? \_\_\_ Yes \_\_\_ No  
If yes, describe: \_\_\_\_\_  
Are you now, or have you ever been, under care for a serious illness, injury or condition? \_\_\_ Yes \_\_\_ No  
If yes, describe: \_\_\_\_\_  
List any prescription medications you are now taking, or take often: \_\_\_\_\_  
List all over-the-counter or herbal medications and vitamins you use: \_\_\_\_\_  
Do you have any other source of medical care? \_\_\_ Yes \_\_\_ No Where? \_\_\_\_\_

YES	NO		YES	NO	
___	___	Vaccine for Rubella(MMR)	___	___	Tattoo/piercing
___	___	Tetanus Vaccine shot (td)	___	___	Hepatitis (B,C) or A & B vaccine(s)
___	___	Abnormal Pap smear	___	___	Pelvic infection/Pain/PID
___	___	Vaginal Infection/discharge/sores	___	___	TB/Communicable Disease

TO THE BEST OF MY KNOWLEDGE, THIS INFORMATION IS COMPLETE AND CORRECT.

**Client Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Comments:** \_\_\_\_\_

**Nurse's Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_