

DEWITT-PIATT BI-COUNTY HEALTH DEPARTMENT
Male Risk Assessment & Contact Treatment

Name _____ Race _____ Date _____
Address _____ City _____ State _____ Zip Code _____
County _____ Age _____ Birthdate _____

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.*

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 high 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
_____	_____	Tattoo/piercing	_____	_____
_____	_____	Tetanus Vaccine shot (Td)	_____	_____
_____	_____	Discharge and/or sores on genitals/penis	_____	_____
			_____	_____
			_____	_____

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

Client Signature: _____ Date: _____

Comments: _____

Nurse's Signature: _____ Date: _____