NYC Health

Triage Staff

WELCOME TO OUR CLINIC

Number

Legal Last Name:	Legal First Name:	Middle Initial:	Date of Birth:

What name do you go by, if different from above?	Mother's Maiden Name:

What are your pronouns? ☐ She/Her ☐ He/Him ☐ They/Them ☐ Other (specify)

How would you describe your gender?	What sex were you assigned at birth?
☐ Man ☐ Woman ☐ Transgender Man ☐ Transgender Woman ☐ Gender non-conforming ☐ Non-binary	☐ Male ☐ Female ☐ Intersex

What form of photo ID did you bring today? ☐ Driver's license ☐ Learner's permit ☐ Student ID ☐ Other ☐ None

ID #:

Address:	Apt. #:	ZIP Code:

State:	Borough: ☐ Bronx ☐ Brooklyn ☐ Manhattan ☐ Queens ☐ Staten Island ☐ Non-NYC resident City (if non-NYC resident):

Phone Number:	Type: ☐ Cell ☐ Home ☐ Work	Cell Phone Carrier:
Alternate Phone Number:	Type: ☐ Cell ☐ Home ☐ Work	Cell Phone Carrier:
Email Address:		

Who should we contact in case of an emergency? Name:

What is their relationship to you?

Phone number where they can be reached:

Were you born in the United States/Puerto Rico? ☐ Yes ☐ No

If not, in what country were you born?

How do you describe yourself? (Check all that apply.)		How do you describe yourself?
☐ White	☐ American Indian/Alaska Native	☐ Hispanic/Latino(a)
☐ Black/African American	☐ Native Hawaiian/Pacific Islander	☐ Non-Hispanic/Latino(a)
☐ Asian	☐ Other	

What language do you speak at home most of the time? ☐ English ☐ Spanish ☐ Other (please specify):

What is your relationship status?		What is your housing status?	
☐ Married	☐ Domestic Partner	☐ Stably housed	☐ At risk of losing housing
☐ Cohabitating	☐ Widowed	☐ About to lose housing	☐ Homeless/Living in a shelter
☐ Separated/Divorced	☐ Single		

Who do you live with? (i.e., roommates, family)

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Check all that apply so we may give you the best possible care.

☐ I have been to a NYC Health Department Sexual Health Clinic before today.

☐ I received a letter, call, text message or home visit telling me to come to clinic.

☐ I have an appointment with a social worker.

☐ I have an appointment with a patient navigator.

☐ I tested positive for an STI and I am here for treatment.

☐ I have recently been told by my doctor or nurse that I currently have syphilis.

☐ I am here for a vaccination.

☐ I am here with my sex partner(s) today.
What number or letter does each partner have? ____________

☐ I am here because my sex partner has an STI.

☐ I or my partner attended an STI testing day at school.

☐ I have a drip, discharge, burning or itching from my genitals, penis or vagina today.

☐ I have a discharge or pain in my anus (butt) today.

☐ I have a sore, cut, bump or wart today. (Indicate where: ________________________)

☐ I have a rash today. (Indicate where: ________________________)

☐ I have no symptoms. I am here for STI testing **only**.

☐ (If you menstruate) The **first day** of my last menstrual period was _______ /_______ /_______

☐ I am here for emergency contraception (Plan B).

☐ I am a man who has had sex with a man **in the past year.**

Thinking about the **past 2 months only**, please check **all** that apply:
☐ 1. I had sex with someone who has HIV.
☐ 2. I had sex with a man who has sex with men.
☐ 3. I had sex with someone who injects drugs.
☐ 4. I had sex with someone in exchange for money or drugs.
☐ 5. I inject non-prescription drugs.
☐ 6. I was sexually assaulted.

I am here for HIV post-exposure prophylaxis (PEP). ☐Yes ☐No

I am here for a **follow-up visit** for (circle all that apply)
ART / PEP (currently taking)/ PEP (recently finished) / PrEP / Vaccination / Syphilis

The other reason I came in today is:

If any of your test results come back positive, would you think about harming yourself or somebody else? ☐ Yes ☐ No

Is anyone abusive to you? ☐ Yes ☐ No

Do you feel unsafe at home? ☐ Yes ☐ No

For Official Use Only

☐ EMR #_______________
☐ Maven #_______________

Services Needed

Clinician:
☐ Evaluate symptoms
☐ Treatment_____________
☐ Vaccine_______________
LDE___________________
If <72 hours:
Condomless ☐Yes ☐No
☐ rec ☐ ins ☐ idu
☐ Other______________
PEP ☐ acc ☐ dec ☐ n/a
EC ☐ acc ☐ dec ☐ n/a
☐UPT

Phlebotomist:
☐ HIV PEP
HIV PEP f/u ☐ 3w ☐ 6w
Syphilis ☐ Screen
☐ Monitor
☐ Decline
☐ n/a
☐ STAT RPR
HIV ☐ Rapid only
☐ Rapid and pNAAT
☐ Decline
☐ n/a

0 Date: ______________
1 Date: ______________ y/n

Other:
Urine ☐ acc ☐ dec ☐ n/a
OP ☐ acc ☐ dec ☐ n/a
AR ☐ acc ☐ dec ☐ n/a
Vag ☐ acc ☐ dec ☐ n/a
☐ SW
☐ Nav
☐ PHAdv

Visit Type
☐ Clinician
☐ Screening
☐ HIV testing only
☐ Anon ☐ Other