Reguler Visit

Answer the questions below and have a seat. You will be called by the number listed on this form.

Check-In # 69

Name: DOB: MRN:

1. Have you ever been seen at this clinic? ☐ Yes ☐ No
2. Do you have a rash? ☐ Yes ☐ No
3. Do you have a sore on your penis, vagina or rectum (butt)? ☐ Yes ☐ No
4. Do you have burning or discomfort with urination (pee)? ☐ Yes ☐ No
5. Do you have discharge from your penis, vagina or rectum (butt)? ☐ Yes ☐ No
6. Do you have testicular pain? ☐ Yes ☐ No
7. For Females only, are you pregnant or have lower abdominal pain? ☐ Yes ☐ No
8. Did a sex partner tell you to get tested or that they have an STD? ☐ Yes ☐ No
9. Did someone from this Clinic call you to come in? ☐ Yes ☐ No

   Name of Staff Member: ______________________

10. Have you been sent here by a doctor or medical facility or have you recently tested positive STD? ☐ Yes ☐ No
11. Are you here for court ordered HIV testing? ☐ Yes ☐ No
12. Are you here for results only? ☐ Yes ☐ No
13. I have no symptoms, I just want to be tested (Answer questions A-B below). ☐ Yes ☐ No

    A. Gender:

       ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male

    B. Select the gender of your sex partner(s) in the last six month (Select all that apply):

       ☐ Male ☐ Female ☐ Transgender Male to Female ☐ Transgender Female to Male

14. Other reason not listed: ______________________