

Lamprey Health Care

Title X Program

History & Risk Assessment Form

Today's Date ____ / ____ / ____

Your name _____

Date of Birth ____ / ____ / ____

Have you ever used needles to inject drugs? YES NO
If yes, have you shared needles in the past three months? YES NO

Have you had more than one partner in the past three months? YES NO

Are your sexual partners: Male Female Both

Have you had sex in exchange for money, drugs, or shelter in the past three months? YES NO

Have you ever been treated for a sexually transmitted disease? YES NO
If yes, what were you treated for? _____
When were you last treated for the above? _____

Do you have a sex partner who uses needles to inject drugs? YES NO

If you are male, have you ever had sex with another male? YES NO

If you are female, do you have a male sex partner who has sex with other men? YES NO

Do you have a sex partner who has a sexually transmitted disease? YES NO

Do you have a sex partner who has tested **positive** for Hepatitis B? YES NO

In the past three months, have you had sex with someone who exchanges sex for money, drugs or shelter?

How many sexual partners have you had in your lifetime: _____ In the past 3 months: _____

When was the last time you had sex without a condom? _____

Please check **ANY** of the following symptoms you are experiencing at this time, or have experience:

- Pain or burning when you urinate (pee)
- Unusual discharge from your penis or vagina
- Bleeding after sexual intercourse
- Genital itching
- Sores on your genitals or anywhere else
- Rash

Please write/describe any other symptoms you are concerned about: _____

