New Patient Intake Form

Last Name: _____ **First Name:** _____

Today's date: _____ **Date of birth:** _____

I identify as (Circle all that apply):

Man	Afro-Carribean Black	Person who injects drugs
Trans (woman)	A man who has sex with men	Woman
Trans (man)	Indigenous	

Are you currently working?	❑ Yes	❑ No
Are you a student?	❑ Yes	❑ No

Family Physician: _____

Allergies:

_____ _____ _____

Current Medications (name and dose):

_____ _____ _____

_____ _____ _____

Past Medical History Do you presently or have you ever had any of the following? Circle **all** that apply:

Allergies	Depression	Hepatitis C	Osteoporosis / Osteopenia
Arthritis	Digestive Problems	High Blood Pressure	Pacemaker
Asthma	Epilepsy / Seizures	High Cholesterol	Skin Disease or Sensitivity
Cancer	Fatigue	Kidney Disease	Stroke
Chronic Fatigue / Fibromyalgia	Heart Problems	Liver Disease (Fatty Liver)	Thyroid Problems
Diabetes	Hepatitis B	Lung Problems	Other:_____

Current Drug Coverage:

❑ Private Drug Plan ❑ ODB/ODSP ❑ Trillium ❑ OHIP+ (under 25) ❑ No Current Coverage

Lifestyle:

Are you a current smoker? ❑yes ❑ no If yes how many cigarettes per day: _____

Do you drink alcohol? ❑ yes ❑ no If yes how many drinks per week: _____

Do you use any other substances? ❑ yes ❑ no Which substances and how often:_____

Sexual History:

Do you have sex with (check all that apply):

❑ males ❑ females ❑ trans men ❑ trans women

Do you use condoms for receptive anal or vaginal sex (Check all that applies)?

- ❑ Never with spouse/boyfriend/regular partner
- ❑ Always with casual partners
- ❑ Sometimes with casual partners
- ❑ Never
- ❑ Always
- ❑ Only have insertive sex (top)

Date of your last HIV test: _____ **Date of your last STI test**: _____

Have you ever been diagnosed with an STI: ☐ yes ☐ no

If yes, please indicate what you were diagnosed with and when:

❑ Syphilis When? _____ Symptoms?_____ Treated with: _____

❑ Chlamydia When? _____ Symptoms?_____ Treated with: _____

❑ Gonorrhea When? _____ Symptoms?_____ Treated with: _____

❑ Herpes When? _____ Symptoms?_____ Treated with: _____

Have you ever used PEP (Post Exposure Prophylaxis): ☐ yes ☐ no

If yes, how many times? ☐ Once ☐ More than once

Date of last occurrence: _____

Risk Questionnaire for men who have sex with men:

What is your age today?

❑ <18 ❑ 18-28 ❑ 29-40 ❑ 41-48 ❑ >49

In the last six months how many men have you had sex with?

❑ >10 ❑ 6-10 ❑ 0-5

In the last six months how many times did you have receptive anal sex (you were the bottom) with a man without a condom?
❑ 0 ❑ 1 or more

In the last six months how many of your male sex partners were HIV positive?

❑ 0 ❑ 1 ❑ more than one

In the last six months how many times did you have insertive anal sex (you were the top) without a condom with a man who was HIV positive?

❑ 0-4 times ❑ 5 or more times

In the last six months have you used methamphetamines such as crystal or speed?

❑ yes ❑ no

In the last six months have you used poppers (amyl nitrate)?

❑ yes ❑ no

How did you hear about our clinic? (Circle)

Google	Family Doctor	Employer
Facebook	Website	Returning patient
Advertisement on Grindr/Scruff	Maple Leaf Medical Clinic	Other_____
Friend / Family	Maple Leaf Medical Pharmacy	
519	St. Michael's Hospital PrEP Clinic	
Act	Toronto General Hospital PrEP Clinic	
Hassle Free	Pharmacy	
Medsexpert Pharmacy	Public Health Unit	