PrEP Clinic
New Patient Intake

Last Name: _____ First Name: _____

Date of Intake: _____ DOB: _____

I identify my gender as: ☐ Man ☐ Woman ☐ Trans* ☐ _____

Family Physician: _____

Current Medications (name and dose):

_____ _____ _____

_____ _____ _____

Allergies:

_____ _____ _____

Past Medical History

Do you presently or have you ever had any of the following? Check all that apply.

- ☐ Kidney Disease
- ☐ Liver Disease (Fatty Liver)
- ☐ Stroke
- ☐ Allergies
- ☐ Asthma
- ☐ Heart Problems
- ☐ Pacemaker
- ☐ High Cholesterol
- ☐ Lung Problems
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Other _____
- ☐ Arthritis (eg. Rheumatoid)
- ☐ Chronic Fatigue / Fibromyalgia
- ☐ Thyroid Problems
- ☐ Depression
- ☐ Epilepsy / Seizures
- ☐ Viral Hepatitis
- ☐ Fatigue
- ☐ Cancer
- ☐ Digestive Problems
- ☐ Skin Disease or Sensitivity
- ☐ Asthma

Have you ever been diagnosed with an STI? ☐ Yes ☐ No

If yes, check all that apply: ☐ Syphilis ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ HPV

Social & Sexual History

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 have sex with (check all that apply):
☐ Males ☐ Females ☐ Trans men ☐ Trans women

Current Drug Coverage:
☐ Private Drug Plan ☐ ODB/ODSP ☐ Trillium ☐ No Current Coverage

How did you hear about our clinic? (Check all that apply and circle the primary source)

☐ Online
☐ Friend
☐ Doctor
☐ Other _____

Risk Questionnaire

(Men who have sex with men including trans men, trans women who have sex with men) **:**

1. How old are you today?

   a. <18 Score 0
   b. 18-28 Score 8
   c. 29-40 Score 5
   d. 41-48 Score 2
   e. >49 Score 0

2. In the last 6 months how many men or trans women have you had sex with?

   a. >10 Score 7
   b. 6-10 Score 4
   c. 0-5 Score 0

3. In the last six months how many times did you have receptive anal sex (you were the bottom) without a condom?

   a. 1 or more Score 10
   b. 0 Score 0

4. In the last six months how many of your sex partners were HIV positive with a detectable viral load?

    a. >1 Score 8
    b. 1 Score 4
    c. 0 Score 0

5. In the last six months how many times did you have insertive anal sex (you were the top) and did not use a condom?

    a. 5 or more Score 6
    b. 0-4 Score 0

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

    a. Yes Score 6
    b. No Score 0

7. I have previously been diagnosed with chlamydia or gonorrhea in my rectum

    a. Yes
    b. No

8. I have previously been diagnosed with syphilis

    a. Yes
    b. No

9. I have used post-exposure prophylaxis (PEP or nPEP) more than once

    a. Yes
    b. No

10. I inject drugs and sometimes share needles

    a. Yes
    b. No

Score on items 1 through 6 _____
(PrEP indicated with score above 10, PrEP a priority if score above 25)

Number of other high risk indicator (items 7-10) _____
(PrEP indicated with 1 or more factors indicated)

Risk Questionnaire

(Anyone whose partners are exclusively women or trans men OR women who have sex exclusively with men):

1. In the past six months I have had more than one sexual partner with whom I haven't used condoms

    a. Yes
    b. No

2. I have previously been diagnosed with syphilis

    a. Yes
    b. No

3. In the past six months I have had a sexual partner who is known to be HIV positive with a detectable viral load

    a. Yes
    b. No

4. I have used post-exposure prophylaxis (PEP or nPEP) more than once

    a. Yes
    b. No

5. I inject drugs and sometimes share needles

    a. Yes
    b. No

- If yes to any of 3, 4, 5, PrEP is indicated
- If yes to items 1 and/or 2 only, PrEP may be needed; assess patient for other potential risks/indicators
- If no to all, PrEP not indicated; if patient is still interested in PrEP, assess for other potential risks/ indicators

PrEP Clinic Follow-up Visit

Last Name: _____ First Name: _____

Since your last visit have you had any new medical problems? ☐ yes ☐ no
If yes, please describe:_____

Any missed doses of PrEP? ☐ Yes ☐ No

If yes, how many doses have you missed per week: ☐1 ☐ 2 ☐ 3 ☐ >3

Any side effects from PrEP? ☐ Yes ☐ No
If yes, please describe:_____

In the last two weeks have you had any of the symptoms below (check all that apply)?

☐ Fevers ☐ Chills ☐ Sore throat ☐ Headache ☐ Diarrhea ☐ Swollen lymph nodes ☐ Rash

Have you had any symptoms of an STI (check all that apply)?

☐ Discharge ☐ Painful urination ☐ Sores or lesions on genitals ☐Warts ☐ Rash

☐ Other: _____