



SEXUALLY TRANSMITTED INFECTION/HUMAN IMMUNODEFICIENCY VIRUS/ HEPATITIS RISK ASSESSMENT AND REDUCTION PLAN

NORTH DAKOTA DEPARTMENT OF HEALTH
SFN 58942 (2-08)

Please fill in your answer or check the appropriate box.
All information is CONFIDENTIAL and will help us meet your needs.

Date

Client Information

Name		Birth Date	
Address			
City	State	Zip Code	Telephone Number

Sex
<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Transgender – M2F <input type="checkbox"/> Transgender – F2M
Race
<input type="checkbox"/> American Indian or Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native HI/Pacific Islander <input type="checkbox"/> White

Risk Assessment

1. Why do you want to be tested?
2. How many people have you had sex with in your lifetime? <input type="checkbox"/> 0 <input type="checkbox"/> 1 – 5 <input type="checkbox"/> 6 – 10 <input type="checkbox"/> 11 – 20 <input type="checkbox"/> 20+
3. How many people have you had sex with in the last 3 months?
4. My sex partners are (check all that apply): <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both Men and Women
5. Do you participate in anal sex? <input type="checkbox"/> Yes <input type="checkbox"/> No
6. Do you participate in oral sex? <input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you participate in vaginal sex? <input type="checkbox"/> Yes <input type="checkbox"/> No
8. When you have sex do you use condoms or other barrier? <input type="checkbox"/> Always <input type="checkbox"/> Most of the time <input type="checkbox"/> Not that often <input type="checkbox"/> Never
9. Have you ever been tested for HIV? <input type="checkbox"/> Yes Date of previous test / / <input type="checkbox"/> No
10. Check any disease or condition you have had. <input type="checkbox"/> Syphilis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Genital/Sex Warts <input type="checkbox"/> Hepatitis C <input type="checkbox"/> Herpes <input type="checkbox"/> Hepatitis A <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Gonorrhea (Clap) <input type="checkbox"/> Trichomonas (Trich) <input type="checkbox"/> HIV <input type="checkbox"/> Men – burning or drip from penis (not gonorrhea or chlamydia) <input type="checkbox"/> Women – infection in your tubes/womb (PID). <input type="checkbox"/> HPV/Abnormal PAP. When?
11. Could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Not Sure Date of last period

