TB/HIV/STD Risk Assessment Interview

Community Counseling Services

Rev 01/17

Case Name _____

Case ID# _____

Date _____

1.	Have you ever tested positive, been diagnosed with, or treated for tuberculosis (TB)?	□Yes	□No
2.	Has anybody you know or have lived with been diagnosed with or tested positive for TB in the past year?	□Yes	□No
3.	Have you ever been told that you have a positive HIV test? (test for the AIDS virus)	□Yes	□No
4.	Do you have a history of IV drug usage?	□Yes	□No
5.	Have you used cocaine (I.E., powder, crack….etc.)?	□Yes	□No
6.	Within the last month, have you had any of the following symptoms lasting for more than 2 weeks? If yes, please check items below.	□Yes	□No

a. □Fever □Drenching night sweats □Coughing up blood

□Losing weight □Shortness of breath □Lumps or swollen glands

□Diarrhea lasting more than one week

b. Are you now living with someone with any of the following? □Yes □No

□Coughing up blood □Drenching night sweats □Active TB

7.	Have you ever engaged in unprotected vaginal, anal or oral sex with multiple partners and/or anonymous partners?	□Yes	□No
8.	Have any of your current or previous sex partners used IV drugs or been HIV positive?	□Yes	□No
9.	Have you ever been paid to have sex or to exchange sex for food, shelter, etc.?	□Yes	□No
10.	Have you ever been the victim of sexual assault?	□Yes	□No
11.	Have you ever used alcohol or drug before or during sex?	□Yes	□No
12.	Have you been diagnosed with or treated for hepatitis and/or a sexually transmitted disease?	□Yes	□No
13.	Have you ever lived on the street or in a shelter?	□Yes	□No
14.	Have you ever been incarcerated or in jail?	□Yes	□No
15.	Have you had a blood transfusion prior to 1992?	□Yes	□No
16.	Were you born between the years 1945 and 1965?	□Yes	□No

Comments:

_____ _____

Staff Signature/Credentials Date