Woman to Woman Gynecology

A-All Women Care　7908 W. Sahara Ave. Las Vegas, NV 89117　(702) 531-5400

PATIENT INFORMATION
Información Del Paciente

Today's Date: ______________
Fecha

Name: (Last, First): ____
Nombre

Date of Birth:_____/______/_______ (Month / Day / Year)　Age:__________　Social Security #:_____-_____-_______
Fecha de Nacimiento　*Edad*　*Seguro Social*

Address: ____Apt#:________
Dirección

City:______________________State:________________ Zip Code:______________
Cuidad　*Estado*　*Código Postal*

Home Phone#:________________________ Cell Phone#: _________________________
Teléfono de casa　*Teléfono de celular*

Email Address:____
Correo Electrónico

Employer:__________________________ Occupation:__________________________
Empleador　*Ocupacion*

Work Phone#:____________________
Teléfono de trabajo

Marital Status (Circle one):　Single　Married　Divorced　Separated　Widowed
Estado Civil　*Soltera*　*Casada*　*Divorciada*　*Separada*　*Viuda*

Race: ☐ White　☐ Asian　☐Pacific Islander　☐ Black or African American

☐ Native American Indian　Other:_______________

Ethnicity: ☐Hispanic or Latino　☐Not Hispanic or Latino　Specify: _______________

EMERGENCY CONTACT INFROMATION
En Caso de Emergencia Notifique

Emergency Contact: ____
Contacto de Emergencia

Phone: _________________________ Relationship: _________________________
Teléfono　*Relación*

Nearest Friend or Relative Not living with you: ____________________________
La Persona o Amistad que no Vive con Usted

Phone:_________________________ Relationship:_________________________
Teléfono　*Relación*

PRIMARY INSURANCE INFORMATION

Información de Seguranza Pimaria

Primary Insurance:______________________ Policy#:______________________
Seguro Primario *Number de Póliza*

Claims Address:______________________ City: ______________________
Dirección de Reclamar *Cuidad*

State:__________ Zip Code: ______________ Phone#: ______________
Estado *Código Postal* *Teléfono*

Policy Holder:______________________ Insured D.O.B ____/_____/________
Tenedor de una Póliza *Fecha de Nacimiento*

Relationship to Patient: __________ Social Security of Insured: ______________
Relación *Seguro Social del Asegurado*

Employer: ________________ Occupation: ______________________
Empleador *Trabajo*

SECONDARY INSURANCE INFORMATION

Información de Seguranza Secundaria

Primary Insurance:______________________ Policy#:______________________
Seguro Secundario *Number de Póliza*

Claims Address:______________________ City: ______________________
Dirección de Reclamar *Cuidad*

State:__________ Zip Code: ______________ Phone#: ______________
Estado *Código Postal* *Teléfono*

Policy Holder:______________________ Insured D.O.B ____/_____/________
Tenedor de una Póliza *Fecha de Nacimiento*

Relationship to Patient: __________ Social Security of Insured: ______________
Relación *Seguro Social del Asegurado*

Employer: ________________ Occupation: ______________________
Empleador *Trabajo*

2023 Office Policies

Insurance Policies and Payments:

Our goal is to provide you with the best possible care. We want to be efficient, effective and diligent in our interactions with you. We cannot practice good medicine or business without timely payments.
As a result, **all payments are due at the time of service.**

Our office is NOT contracted with most insurance and does not accept insurance fee schedules.
Our fee schedules are based on 120-150% of Medicare rates**.**

___________________**Patient Initials**

Labs and Testing:

We are not contracted with Insurances for Office Visits or Procedures done in office. We are able to use insurances toward labs or testing done in office. If we send out your specimen (s) to a lab for processing though your insurance we are not responsible for any bills you receive from the lab.

If you do not have insurance, or would prefer not to use your insurance, you are responsible for paying the lab fee in our office. You are also responsible for calling the lab within 24 hours for Pap smear collections for the discounted price.

We are not responsible for any bills you have received from the lab.

___________________**Patient Initials**

Communications with Patient:

By supplying my telephone number, I understand that I may receive calls or text message reminders from our office. Phone calls may be made in regard to office visits, test results, or medications. We will not discuss any information over the phone until we have confirmed we are speaking directly to you. If you are unable to answer the phone, we will leave a general message that does not disclose any Personal Health Information.

Text Messages are for appointment reminders. Receiving them is completely optional. You may opt out of them at any time.

___________________**Patient Initials**

Balances on Accounts:

Your balance will be due at your follow up visit, unless, there are special circumstances, such as, payment arrangements scheduled in collaboration with the office manager.

____________________**Patient Initials**

Credit Card Payments:

A 3.99% fee will be applied when services are paid by credit or debit on all transactions. There is no additional charge of 3.99% when paying with cash.

____________________**Patient Initials**

Cardholder Policy:

It is our policy that the cardholder be present at the time of the appointment. Any charges that are refuted if the cardholder is not present will become the patient's responsibility.

____________________**Patient Initials**

Prescription refills:

No prescriptions will be refilled unless the account is paid in full or is up-to-date with the payment schedules. All prescriptions must first be approved by Dr. Anna Contomitros.

We are unable to fill prescriptions for Birth Control over 3 months unless an Annual Exam has been completed.

____________________**Patient Initials**

Acknowledgement of the Notice of Privacy Practices

I hereby acknowledge that I have reviewed the "Notice of Privacy Practices" from Woman to Woman Gynecology. I understand that the "Notice of Privacy Practices" sets forth my rights relating to the use and disclosure of my personal health information and explains how Woman to Woman Gynecology use and disclose my personal health information, both with and without my authorization. I further understand that I many contact Woman to Woman Gynecology if I have any questions regarding the contents of this notice, or to file a complaint.

__________________**Patient Initials**

Missed Appointment Policy

Should you cancel your appointment in less than 24 hours, or not show up for your appointment without giving us a courtesy call, there will be a **$55.00** charge applied to your account for the missed appointment date. This amount is payable prior to the provision of any other future services.

We contact via SMS/Phone call in advance with a reminder of their visit time.

Attestation by patient:

I am aware of the policies and I understand that I will be charged for late cancellations of appointment or for not showing up for my scheduled services.

__________________**Patient Initials**

Collaboration between Patients and Office Providers:

We desire to help you at all times. Getting better, feeling well and being satisfied requires our mutual collaboration. So, we absolutely need your help in taking care of you! Failure to follow up with our instructions to do testing, to get your mammograms, biopsies, consultations, failure to show up for your appointments, repeatedly canceling your appointment, all will be considered as an indication that our collaboration in your best interest is not working. We will dismiss patients from our practice that are not civil to our staff and who are inconsistent with their health commitments or their payments to our practice.

We have zero tolerance for obscenities or any form of verbal or physical violence. We do not allow weapons in our office. We do not allow unauthorized photos of our staff and doctor.

Name____**Date**______________________________

Signature____ **Date:** ______________________________

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Release of Records:

If anyone were to call on your behalf, we are unable to disclose any information about you, your office visit, or your test results unless they are listed below. You do have the option of marking “No one”.

I, ________________________________, give Anna Contomitros, M.D. of A-All Women Care and Woman to Woman Gynecology, the authorization to release and discuss any information about myself and the following people.

- ○ No one
- ○ ________________________________ ________________________________
  Name Relationship
- ○ ________________________________ ________________________________
  Name Relationship
- ○ ________________________________ ________________________________
  Name Relationship
- ○ ________________________________ ________________________________
  Name Relationship

I understand that is my full responsibility to notify the office of any changes.

Signature:____ Date: ________________________

Date:

Woman to Woman Gynecology

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Last name:____________________ First name:____________________ Date of birth:__________________

Last Menstrual Period:__________________ Was it normal? Yes No If No, please describe:__________________

Are you menopausal or postmenopausal? Yes No I experience no more periods due to:______________________

____

Why are you here today?

- O Routine Annual Visit with **NO** problems
- O Are you having any gynecologic problems you want to discuss with the doctor?______________________________________

____

____

____

____

Are you **CURRENTLY** experiencing any of the following (please circle those that apply): ☐ **Select if none**

Neurological: dizziness, numbness in arms or legs, trouble walking, other: ______________________________

Eyes: double vision, spots before eyes, vision changes, other: ___________________________________

ENT/Mouth: ear aches, ringing in ears, sinus problems, sore throat, mouth sores, other: ____________________

Cardiovascular: swelling of the legs, chest pain, blood clots in legs or lungs, other: __________________________

Respiratory: spitting up blood, shortness of breath, coughing, other: ___________________________________

Gastrointestinal: diarrhea, constipation, nausea or vomiting, bowel trouble, blood in stool, black stools, incontinence of stool, other: ____

Genitourinary: blood in urine, painful urination, frequent urination, painful intercourse, vaginal: discharge, odor, or itching, urine incontinence, other: _________________________________

Musculoskeletal: muscle pain, joint pain, muscle weakness, joint weakness, other: ___________________________

Constitutional: weight loss, weight gain, fatigue, fever, changes in appetite, difficulty sleeping, other: __________

Endocrine: hot flashes, abnormal thirst, other: ____

Hematologic/Lymphatic: enlarged lymph nodes, continuous bleeding, bruising easily, other: _________________________

Psychiatric: thoughts of suicide, frequent crying, depression, anxiety, other: ____________________________

MEDICATION INFORMATION

Please list the **PHARMACY** you would like us to use if you needed a prescription. Name and cross streets or phone number.

____

Do you have any **ALLERGIES** to medications, latex, or iodine? If so, please list them and your reactions:

____

____

____

____

List any **MEDICATIONS** (prescription and over the counter), **Vitamins, or supplements** you are taking and the dosage.

Name Dose

____

____

____

____

Do you smoke tobacco (select applicable choice)?

- O Current every day smoker
- O Current some day smoker
- O Former smoker
  Date Quit:_____________
- O Never smoker

Do you use any smokeless tobacco, if so how often? ____

Do you drink alcohol ever, if so how often and how many drinks average? ______________________________

Do you use any street drugs, if so please list names and last time used?______________________________

Date:

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PREVENTIVE CARE

When was your last?	Date	Was it normal?			If No, explain:
Pap smear	______	Yes	No	N/A	______
Mammogram	______	Yes	No	N/A	______
DEXA Scan	______	Yes	No	N/A	______
Colonoscopy	______	Yes	No	N/A	______

Have you had the following (mark all that apply and dates): ☐ **Select if none**

- O Gardasil vaccine (ages 9-26 for the prevention of cervical cancer and genital warts:______
- O Flu vaccine: ______
- O Pneumococcal vaccine______

PREGNANCY HISTORY ☐ Select if none

How many times have you been pregnant? ______

How many children do you have? ______

How many vaginal deliveries?______

How many C-Section deliveries?______

How many ectopic/tubal pregnancies?______

How many miscarriages?______

How many abortions?______

Describe any problems you had during the prior pregnancies, **include details**: ☐ **Select if none**

- O Rh Negative
- O Severe bleeding requiring transfusions
- O Diabetes
- O High Blood Pressure
- O Clots in the lungs or legs (DVT)
- O Infections
- O Congenital anomalies
- O Any other problems or difficulties:______ ______

CONTRACEPTIVE HISTORY ☐ Select if none

Are you using any contraception **currently**, if so which one? ______

Have you used any of these below?

- O Birth control pills (include names)
- O Nuvaring
- O Ortho-Evra Patch
- O IUD Mirena/Skyla/Paragard
- O Nexplanon
- O Depo-Provera shot
- O Diaphragm
- O Tubal Ligation

Describe any **problems** you had while taking them:______

Please mark if **you currently have or have previously had** any of the following while taking hormonal contraception:

- O Smoker
- O Migraine Headaches
- O High Blood Pressure
- O Breast Cancer
- O Liver Problems
- O Varicose Veins
- O Gallbladder Problems
- O Blood clots of the legs or lungs
- O Family member with blood clots of the legs or lungs

☐ **Select if none**

SEXUAL HEALTH HISTORY ☐ Select if none

- O Difficulties with intercourse
- O Pain with intercourse
- O Dryness with intercourse
- O Inability to have an orgasm
- O Decreased desire for intercourse
- O Bleeding with intercourse

BREAST HISTORY ☐ Select if none

- O Fibrocystic changes
- O Blocked Milk Ducts
- O Cysts
- O Fibroadenomas
- O Intraductal Papillomas
- O Mastitis
- O Nipple discharge
- O Biopsy
- O Breast cancer

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GYNECOLOGIC HISTORY (Please mark those that apply to you, including dates where possible) ☐ **Select if none**

- O Pelvic Infections: Chlamydia, gonorrhea, mycoplasma, ureaplasma
- O Vaginal Infections: yeast, bacterial vaginosis, beta strep
- O Abnormal Pap smear
- O HPV Infection
- O Genital Warts
- O Dysplasia
- O Mollascum contagiosum
- O Trichomonads
- O Heavy or Painful periods
- O Endometriosis
- O Pelvic scarring (adhesions)
- O Uterine fibroids
- O Ovarian cysts
- O Inflamed blocked fallopian tubes (Salpingitis)
- O Uterine Cervical Ovarian Cancer
- O Ovarian Cancer
- O Fallopian Tube Cancer
- O Cervical Cancer
- O Urgency (the sensation to urinate all the time)
- O Frequency: the need to urinate frequently
- O Loss of urine with sneezing, coughing, or laughing
- O Needing to wear diapers or pads to prevent being wet
- O Uterine or vaginal anomalies: double uterus, double vagina, double cervix
- O Nocturia: waking up at night to use the bathroom more than once per night

Prolapse of pelvic organs: ☐ **Select if none**

- O Uterine prolapse
- O Cystocele (prolapse of the bladder)
- O Rectocele (prolapse of the rectum)
- O Enterocele (prolapse of the bowel)

HORMONAL HEALTH HISTORY ☐ **Select if none**

When was menopause for you (year and age)?____

Hormonal Changes (select those that apply to you):

- O Hot flashes
- O Night and day sweats
- O Weight gain
- O Poor Bone Health
  - O Loss of height
  - O Osteopenia
  - O Osteoporosis
  - O Fractures
  - O Vitamin D status
- O Memory loss
- O Dry skin
- O Mood changes
- O Lack of sexual desire
- O Vaginal dryness

FAMILY HISTORY ☐ **Select if none**

Has anyone in your family ever had the following, please list relation and their age of diagnosis if known.

- O Breast Cancer_________________________
- O Colon Cancer_________________________
- O Ovarian Cancer_______________________
- O Endometrial Cancer____________________
- O Cervical Cancer_______________________
- O Diabetes_____________________________
- O High blood pressure___________________________
- O Stroke______________________________________
- O Heart disease________________________________
- O Thyroid disorder_____________________________
- O Addiction____________________________________
- O Seizures/Epilepsy____________________________
- O Other (please describe):____

____

SOCIAL HISTORY

Please mark appropriate sexual orientation:

Heterosexual Bisexual Lesbian

Please select current relationship status:

Single Married Long term monogamous relationship

Separated Divorced Widowed

Please list current occupation: ____

Highest education level (circle one):

Some high school: _____ yrs. Some College: _____yrs. Master's Degree

Graduated High School Associates Degree PhD

GED Bachelor's Degree Technical/Trade school

Date:

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GENERAL HEALTH HISTORY Do you have any of the following?

Neurological:
- O None
- O Seizures/Epilepsy
- O Numbness
- O Other:________________
- O Migraine headaches

Eyes:
- O None
- O Macular degeneration
- O Cataracts
- O Other: ________________
- O Glaucoma

ENT/Mouth:
- O None
- O Other:_________________

Cardiovascular:
- O None
- O Stroke
- O Heart disease
- O Varicosities
- O Blood clots of the legs or lungs (Deep Vein Thrombosis)
- O Circulatory problems (describe): _____________
- O Other: ________________
- O High blood pressure

Respiratory:
- O None
- O Chronic Lung Disease
- O Tuberculosis
- O Seasonal allergies
- O Other: ________________
- O Asthma

Genitourinary:
- O None
- O Urine retention
- O Urine Incontinence
- O Kidney stones
- O Bladder cancer
- O Kidney cancer
- O Other: ________________
- O Kidney disease

Gastrointestinal:
- O None
- O Crohn's disease
- O Gastritis
- O Esophagitis
- O Bowel incontinence
- O Ulcers
- O GERD
- O Colonic polyps
- O Stomach cancer
- O Bowel Cancer
- O H. Pylori infection
- O Hepatitis Infection
- O Other: ________________
- O Ulcerative colitis

Musculoskeletal:
- O None
- O Hernia (location): ______________________
- O Osteoporosis
- O Osteopenia
- O Arthritis
- O Other: ________________
- O Fractures

Endocrine:
- O None
- O Thyroid disorder
- O Thyroid cancer
- O Multiple Endocrine Neoplasia
- O Other: ________________
- O Diabetes

Hematologic/Lymphatic/Autoimmune:
- O None
- O Leukemia
- O Hodgkin's Lymphoma
- O Sjogren's
- O Other:_________________
- O Lupus

Integumentary (Skin):
- O None
- O Melanoma
- O Psoriasis
- O Other:_________________
- O Basal cell carcinoma

Psychiatric: ☐ **Select if none**
- O Addiction (please provide information):___________
  ____
  ____
- O Mental Illness (please provide information): _______
  ____
  ____
- O None
- O Depression
- O Anxiety

Date:

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SURGICAL HISTORY Please list all surgeries and the date of the procedure under appropriate body system.

Neurological (The brain, spinal cord, or nervous system)
- O None
- O Other________________________________

Eye surgery
- O None
- O Cataract removal
- O Other:________________________________

ENT/Mouth:
- O None
- O Tonsillectomy
- O Adenoidectomy
- O Thyroidectomy
- O Parathyroidectomy
- O Other: ________________________________

Cardiovascular:
- O None
- O Angioplasty
- O Cardiac bypass surgery
- O Stent placement
- O Radiofrequency ablation (For abnormal heart rhythm)
- O Heart transplant
- O Other: ________________________________

Respiratory:
- O None
- O Thoracotomy
- O Lobectomy
- O Lung transplant
- O Other: ________________________________

Musculoskeletal:
- O None
- O Knee replacement
- O Hip replacement
- O Other: ________________________________

Breast:
- O None
- O Mastectomy for cancer
- O Lumpectomy
- O Breast implants
- O Other: ________________________________

Gastrointestinal:
- O None
- O Cholecystectomy (Removal of gallbladder)
- O Appendectomy (Removal of appendix)
- O Pancreatectomy (Pancreatic surgery)
- O Colectomy (Removal of part of colon)
- O Hemorrhoidectomy
- O Hernia repair
- O Other:________________________________

Genitourinary:
- O None
- O Hysterectomy (Removal of uterus and cervix)
- O Salpingo -Oophorectomy (Removal of ovaries/tubes)
- O Cystectomy (Removal of ovarian cyst)
- O Myomectomy (Removal of fibroids)
- O Laparoscopy (Looking inside the abdomen)
- O Tubal Ligation (Tie tubes for contraception)
- O Pelvic prolapse (Repair of vaginal hernia)
- O Mesh for prolapse
- O Cystocele repair (Repair of bladder prolapse)
- O Rectocele repair (Repair of rectum prolapse in vagina)
- O Enterocele repair
- O Nephrectomy
- O Lithotripsy
- O Cystoscopy
- O Other: ________________________________

Hematologic/Lymphatic:
- O None
- O Lymph node resection
- O Other:________________________________

Endocrine:
- O None
- O Thyroid surgery
- O Other:________________________________

I have answered all the questions truthfully and I have not withheld any information that might affect my medical care.

Patient Name (Please print):________________________________

Signature of Patient:________________________________ Date:________________

Physician's Signature:________________________________ Date:________________

Southern Nevada Health District
CLINICAL SERVICES

Sexual Health Clinic
Client Health History

Please complete this form as much as possible. All information is confidential

Todays' Reason for Visit

☐ No symptoms or problems, I just want testing
☐ Call from Health Dept.
☐ I have an appointment
☐ Partner/Doctor told me to come
☐ Other (please explain):

☐ I have symptoms **(check all that apply)**
☐ Abnormal discharge ☐Odor ☐Itching ☐Rash
☐ Burning when I pee ☐ Abdominal Pain
☐ Sores/bumps in genital area ☐ Swelling/pain in testicle(s)
☐ Other (please explain):

PATIENT MEDICAL HISTORY Have you ever been told by a doctor, nurse, or other health professional that you have:		**FAMILY HISTORY** (parents, sibling)?	**If yes, list** person
Diabetes? Check all that apply ☐ Gestational Diabetes ☐ Prediabetes ☐ Borderline Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	
☐Heart Attack ☐Angina ☐Coronary Health Disease ☐Stroke?	☐ Yes ☐ No	☐ Yes ☐ No	
☐ High blood pressure ☐ High Cholesterol?	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer?	☐ Yes ☐ No	☐ Yes ☐ No	
Mental Illness?	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Kidney Disease ☐ Urinary Tract Infections?	☐ Yes ☐ No	☐ Yes ☐ No	
Seizures?	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Asthma ☐ TB ☐ Lung Problems?	☐ Yes ☐ No	☐ Yes ☐ No	
☐ Hepatitis ☐ Liver problems?	☐ Yes ☐ No	☐ Yes ☐ No	

Other Chronic Health Problems:

Hospitalizations:

Prior sexually transmitted diseases (check all that apply): ☐ **Select if none** ☐ Gonorrhea ☐ Syphilis
☐ Trichomoniasis ☐ Herpes ☐ Genital Warts ☐ Chlamydia ☐ Pelvic Inflammatory Disease ☐ Hepatitis

Diagnosed with HIV? ☐ Yes ☐ No IF yes, the date diagnosed: ______________
Diagnosed with AIDS? ☐ Yes ☐ No IF yes, the date diagnosed: ______________
Do you see a doctor/provider? ☐ Never ☐ Within past 6 months ☐ More than year
Date last seen by provider: ___________________ Where: _________________ Reason: ________________
____

Did you receive a flu vaccine this year: ☐ Yes ☐ No Other vaccines?

Allergies (drugs/ others)? ☐ Yes ☐ No If yes, list:

List all HIV medications ever taken:

List all other medications taken **in the past 2 weeks:**

FEMALES ONLY: Date of last period: _______ Date of last Pap smear: ______ Pregnant? ☐Yes ☐No ☐Unsure

Do you use birth control? ☐ Yes ☐ No If yes, list:

SNHD Southern Nevada Health District CLINICAL SERVICES

Sexual Health Clinic
Client Health History

SOCIAL HISTORY

Do you use tobacco products such as: (check box)
☐Cigarettes ☐ Smokeless tobacco ☐ Electronic vapor product ☐Hookah ☐ Pipe ☐ Chew

Do you: (check box) ☐ Drink alcohol ☐ Take street drugs ☐ Inject drugs ☐ Share needles/equipment

Are you experiencing domestic violence, sexual violence or human trafficking?
☐ Yes ☐ No If **yes**, would you like information or help today? ☐ Yes ☐ No

SEXUAL HISTORY

Have you traveled outside of the United States in the past 60 days? ☐ Yes ☐ No **If yes, where?**

# of sexual partners in the last 90 days ______	# of sexual partners in the last 12 months _____	# of sexual partners in your lifetime _______	When was the last time you had sex? __________________

In the last 12 months I have had sex with:(check all that apply)

☐Women ☐ Men ☐ Transgender Date of last sexual activity:___________________________
☐ **Steady partners** *(people you regularly have sex with)* # of **different** *steady* partners last 3 mons.____
☐ **Casual partners** *(people that you don't have sex with very often)* # of **different** *casual* partners last 12 mons. ____

In the last 12 months my sexual activities include:

Oral sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐
Anal sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐
Vaginal sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐

I use condoms for… **vaginal sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A
I use condoms for… **anal (rectal) sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A
I use condoms for… **oral sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A

Exchanging sex for drugs, money or place to live?	☐ Yes	☐ No	
Having sex while intoxicated or high on drugs?	☐ Yes	☐ No	
Did any of your partners have an STD (including HIV)?	☐ Yes	☐ No	☐ Unsure

Was any of your partners that you had sex with: (check all that apply) ☐ **Select if none**
☐ HIV positive ☐ IV Drug User ☐ Exchanging sex for drugs/money

FEMALES ONLY:
I have had vaginal or anal (rectal) sex with a man who has sex with men ☐ Yes ☐ No ☐ Unsure

SIGNATURE

I have answered all the questions correctly to the best of my knowledge.

______________________________________ ______________________________________ _____________
Print Name of Client **Signature** **Date**