FREDERICK COUNTY HEALTH DEPARTMENT – SUBSTANCE ABUSE SERVICES

Infectious Diseases Screening

Patient Name: _____

********** **The following questions can help you estimate your risk of exposure to transmittable infectious diseases. Exposure means that you MIGHT have become infected. Being infected does not necessarily mean that you will develop active symptoms even if you have a progressive infection. If you have not been tested since your last potential exposure, please ask your counselor about the availability of testing. If you have questions about these of other risk factors, your counselor may ask you to discuss these with your Primary Care Provider or with our agency Medical Director.**

Are you worried you might have HIV, Hepatitis B or C, TB, or a sexually transmitted disease?

☐Yes ☐No. If "Yes" please state why: _____

_____

_____

Please check 'Yes' or 'No' or 'Uncertain' to all of the questions below:

	Yes	No	Uncertain
Exposure to active TB	☐	☐	☐
Blood transfusion prior to 1992	☐	☐	☐
Any contact with another person's blood	☐	☐	☐
Tattoos or piercings	☐	☐	☐
Intravenous drug usage	☐	☐	☐
Crack cocaine use	☐	☐	☐
Blackouts during alcohol/drug use	☐	☐	☐
Shared needles/works for nasal or IV use	☐	☐	☐
Unprotected sex	☐	☐	☐
Have you had a sexually transmitted disease	☐	☐	☐
Any residence in a shelter	☐	☐	☐

Would you like to be tested for:

	Yes	No
TB	☐	☐
HIV	☐	☐
Hepatitis C	☐	☐
Hepatitis B	☐	☐
Sexually transmitted disease	☐	☐
Pregnancy	☐	☐

_____

Patient Signature: Date:

_____

Counselor Signature: Date: