

# HIV Screening Test

<b>Patient Information</b>	
Full Name:	
Date of Birth:	
Gender:	
Contact Number:	
Address:	

<b>Medical History &amp; Related Questions</b>	<b>Response</b>
Have you ever been tested for HIV before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you had unprotected sexual contact in the past 6 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you shared needles or syringes in the past year?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you received blood transfusions before 1985?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you been diagnosed with any other sexually transmitted infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you currently experiencing flu-like symptoms?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Tests	Details
Type of HIV Test:	<input type="checkbox"/> Antigen/Antibody Test <input type="checkbox"/> RNA Test <input type="checkbox"/> Rapid Antibody Test
Date of Test:	

Findings	Details
Test Result:	<input type="checkbox"/> Negative <input type="checkbox"/> Positive <input type="checkbox"/> Indeterminate
Result Value:	
Normal Range:	
Basis of Findings:	

Interpretation	
Interpretation:	

Overall Interpretation	
Notes:	

Doctor's Signature:  Date: \_\_\_\_\_