HIV Screening Test

Patient Information	
Full Name:	
Date of Birth:	
Gender:	
Contact Number:	
Address:	

Medical History & Related Questions	**Response**
Have you ever been tested for HIV before?	☐ Yes ☐ No
Have you had unprotected sexual contact in the past 6 months?	☐ Yes ☐ No
Have you shared needles or syringes in the past year?	☐ Yes ☐ No
Have you received blood transfusions before 1985?	☐ Yes ☐ No
Have you been diagnosed with any other sexually transmitted infections?	☐ Yes ☐ No
Are you currently experiencing flu-like symptoms?	☐ Yes ☐ No

Tests	**Details**
Type of HIV Test:	☐ Antigen/Antibody Test ☐ RNA Test ☐ Rapid Antibody Test
Date of Test:	

Findings	**Details**
Test Result:	☐ Negative ☐ Positive ☐ Indeterminate
Result Value:	
Normal Range:	
Basis of Findings:	

Interpretation	
Interpretation:	

Overall Interpretation	
Notes:	

Doctor's Signature: ______________________________ Date: ________________