

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
HIV TESTING HISTORY AND TREATMENT QUESTIONS

Information below is required for all new HIV reports and
will be used to generate incidence estimates

Date Questions Answered by Client (mo/day/year): ____/____/____

Site Completing Form: _____ Phone () _____-

Person Completing Form: Last _____ First _____

Completed By: Interviewer/Counselor Client/Patient Chart Review

Client Name: Last _____ First _____ MI _____ Date of Birth: ____/____/____

First Positive HIV test reported by client:

Ever had a previous positive HIV test? Yes No Don't Know/Unknown Refused

Date of first positive test (mo/day/year): ____/____/____ (partial dates acceptable)

Specimen type for first positive test: Oral Blood Unknown

Anonymous first test? Yes No Unknown

Negative HIV tests reported by client:

Ever had a negative HIV test? Yes No Don't Know/Unknown Refused

If yes, date of most recent negative test (mo/day/year): ____/____/____ (partial dates acceptable)

of negative tests in 24 months before first positive test: _____ Don't Know/Unk Refused

Antiretroviral treatment (ARV) and prophylaxis:

Ever used ARV to prevent/treat HIV or Hep B? Yes No Don't Know/Unk Refused

If yes, list at least one ARV medication: _____

Dates of ARV use: Date first began: ____/____/____

Currently using ARV? Yes → Date of most recent use (mo/day/year) ____/____/____

No → Date of last use (mo/day/year) ____/____/____

Comments, risk factors or race not noted on HIV Case Report Form: _____
