## GENERAL INFORMATION

Date:

Name: ______________________________ Age: ___ Date of Birth: _____ / _____ / _____

Address: ______________________________ City: ___ State: _ Zip Code: _____

Phone Number: __________________________ Your occupation: _

## REFERRAL SOURCE (circle all that apply)

| | | | | | | |
|---|---|---|---|---|---|---|
| Family | Friend | Agency | Medical Facility | Brochure | Church | Radio |
| Television | Newspaper | Phone Book | High School | Hotline | Counselor | Other |

## MARITAL STATUS (circle all that apply)

Single    Married    Living Together    Separated    Divorced    Widowed

Spouse's Name: ______________________________ Spouse's Occupation: ______________________________

## ETHNIC GROUP (circle one)

African American    Asian    Caucasian    Hispanic    Native American    Other:______

Occupation:________________________________________ Religious Preference:______________________________

## SYMPTOMS (circle all appropriate symptoms – specify duration)

| | | | |
|---|---|---|---|
| None | Discharge | Body rash | Pain with urination |
| Penile itch | Genital rash | Sores/Lesions | |

List any known medical allergies: ____________________________________________________________

| RISK ASSESSMENT | Yes | No | Unk |
|---|---|---|---|
| 1. Drug Use?<br>Type: ____________________<br>2. Sex with males?<br>3. Multiple sex partners?<br>Number in the past year _____<br>4. Partner IV drug user? | | | |

| Medical HX | Yes | No |
|---|---|---|
| Other current or chronic health problems?<br>If YES, list:<br>________________________________<br>________________________________<br><br>Current or recent medication?<br>If YES, list:<br>________________________________<br>________________________________ | | |

| Medical/STD History – STD/HX<br>Have you ever had an STD? List below. | Yes | No | Date |
|---|---|---|---|
| Syphilis | | | |
| Gonorrhea | | | |
| Chlamydia | | | |
| Herpes | | | |
| HPV | | | |
| Other | | | |

Master Forms: Men's Mecical Form 10/10

1328 E. Apache Blvd
Tempe, AZ 85281

# CONSENT FOR MEDICAL TREATMENT

I, ________________________________ hereby agree to receive the following service(s) from
Name (PLEASE PRINT)

AWC Medical Clinic (check one):

- ❑ **Medical Services**
  - Includes STD/HIV screening for men, or basic evaluation by a doctor, nurse, or other qualified personnel.

I hereby give AWC Medical Clinic full consent to any and all procedures performed by AWC Medical Clinic medical staff. I waive and release any and all claims, whatsoever kind and nature, that I, my baby, or legal representative or heirs and realities might have or hereafter have against AWC Medical Clinic, its practitioner, medical personnel, directors, officers, employees, and volunteers.

I expresssly agree that this waiver, release, and indemnity agreement is intended to be as broad and inclusive as permitted by the laws of the state of Arizona, and that if any portion thereof is held invalid, it is agreed that the balance shall, not withstanding, continue in full legal force and effect.

***To provide medical services AWC Medical Clinic must be able to contact you, either by telephone or by mail. Please provide the following information:***

________________________________ ________________
Name (PLEASE PRINT) Telephone Number

________________________________________________
Address City/State Zip Code

***THIS FORM MUST BE SIGNED PRIOR TO RECEIVING ANY SERVICES:***

________________________________ ________________
Patient's Signature Date

________________________________ ________________
AWC Witness Signature Date

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