



**Vaccination History**

Vaccination	Date Received	Re-Vax Date
Pneumovax		
Tetanus toxoid or Tdap		
Hepatitis B vaccine		
Hepatitis A vaccine		
Influenza vaccine		

- Unknown
- Unknown
- Unknown
- Unknown
- Unknown

**Other illnesses, diseases, infections and health concerns**

Check any that client has experienced or is currently experiencing. Specify if it is current or there is history.

		Current or in the last 12 months	Prior history	Date/Result of test
	Abscesses	<input type="checkbox"/>	<input type="checkbox"/>	
	Epilepsy/seizure disorder	<input type="checkbox"/>	<input type="checkbox"/>	
	Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	
	Endocarditis	<input type="checkbox"/>	<input type="checkbox"/>	
	Hepatitis A	<input type="checkbox"/>	<input type="checkbox"/>	
	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	
	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	
	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
	Asthma or COPD	<input type="checkbox"/>	<input type="checkbox"/>	
	Physical disability	<input type="checkbox"/>	<input type="checkbox"/>	
	Chronic diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
<b>STDs</b>				
	Chancroid	<input type="checkbox"/>	<input type="checkbox"/>	
	Herpes simplex	<input type="checkbox"/>	<input type="checkbox"/>	
	Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	
	Trichomonas	<input type="checkbox"/>	<input type="checkbox"/>	
	Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	
	Bacterial vaginosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Perirectal warts	<input type="checkbox"/>	<input type="checkbox"/>	
	Genital warts	<input type="checkbox"/>	<input type="checkbox"/>	
	Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPPORTUNISTIC INFECTONS: MALIGNANCIES</b>				
	Anal cancer	<input type="checkbox"/>	<input type="checkbox"/>	
	Cervical cancer	<input type="checkbox"/>	<input type="checkbox"/>	
	Kaposi Sarcoma	<input type="checkbox"/>	<input type="checkbox"/>	
	Non-Hodgkin Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	
	Hodgkin Lymphoma	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPPORTUNISTIC INFECTONS: PARASITIC INFECTIONS</b>				
	Cryptosporidiosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Isosporiasis	<input type="checkbox"/>	<input type="checkbox"/>	
	Microsporidiosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Cyclosporiasis	<input type="checkbox"/>	<input type="checkbox"/>	
	Amoeba infection	<input type="checkbox"/>	<input type="checkbox"/>	
	Giardiasis	<input type="checkbox"/>	<input type="checkbox"/>	
	Toxoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPPORTUNISTIC INFECTONS: BACTERIAL INFECTIONS</b>				
	Tuberculosis (TB)	<input type="checkbox"/>	<input type="checkbox"/>	
	Mycobacterium avium complex (MAC)	<input type="checkbox"/>	<input type="checkbox"/>	
	Bacterial pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	

		Current or in the last 12 months	Prior history	Date/Result of test
	Nocardia infection	<input type="checkbox"/>	<input type="checkbox"/>	
	Staph infections	<input type="checkbox"/>	<input type="checkbox"/>	
	Bacillary angiomatosis	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPPORTUNISTIC INFECTIONS: VIRAL INFECTIONS</b>				
	CMV	<input type="checkbox"/>	<input type="checkbox"/>	
	Hepatitis B - <b>circle one: chronic or previous</b>	<input type="checkbox"/>	<input type="checkbox"/>	
	Hepatitis C - <b>circle one: chronic or previous</b>	<input type="checkbox"/>	<input type="checkbox"/>	
	Herpes zoster virus ("shingles")	<input type="checkbox"/>	<input type="checkbox"/>	
	Molluscum contagiosum	<input type="checkbox"/>	<input type="checkbox"/>	
	Oral hairy leukoplakia	<input type="checkbox"/>	<input type="checkbox"/>	
	Progressive multifocal leukoencephalopathy (PML)	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OPPORTUNISTIC INFECTIONS: FUNGAL</b>				
	Esophageal candidiasis	<input type="checkbox"/>	<input type="checkbox"/>	
	Pneumocystosis (PcP)	<input type="checkbox"/>	<input type="checkbox"/>	
	Thrush (oral candidiasis)	<input type="checkbox"/>	<input type="checkbox"/>	
	Vaginal yeast infections	<input type="checkbox"/>	<input type="checkbox"/>	
	Histoplasmosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Cryptococcosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Coccidioidomycosis	<input type="checkbox"/>	<input type="checkbox"/>	
	Aspergillosis	<input type="checkbox"/>	<input type="checkbox"/>	
<b>NEUROLOGICAL CONDITIONS</b>				
	AIDS dementia complex (ADC)	<input type="checkbox"/>	<input type="checkbox"/>	
	Peripheral neuropathy	<input type="checkbox"/>	<input type="checkbox"/>	
	Post-herpetic Neuralgia	<input type="checkbox"/>	<input type="checkbox"/>	
<b>OTHERS</b>				
	Aphthous ulcers ("canker sores")	<input type="checkbox"/>	<input type="checkbox"/>	
	Thrombocytopenia (low platelets)	<input type="checkbox"/>	<input type="checkbox"/>	
	Anemia (low red blood cells)	<input type="checkbox"/>	<input type="checkbox"/>	
	Leukopenia (low white blood cells)	<input type="checkbox"/>	<input type="checkbox"/>	
	Wasting syndrome	<input type="checkbox"/>	<input type="checkbox"/>	
	Depression	<input type="checkbox"/>	<input type="checkbox"/>	

**What are some past and present health concerns related to your HIV disease**

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