Screening Form for PrEP
Start Up or Follow-Up Visits

Date of Birth (DD/MM/YYYY) _____/_____/_____

What is your sex? Male [ ] Female [ ]

Tick what is applicable.

***** ***Consider offering PrEP***

1. In the past 6 months: How many people did you have vaginal or anal sex with?

	0	1	2+*
Men			
Women			

2. In the past 6 months: Did you use a condom every time you had sex?

Yes	No*	Don't Know*

3. In the past 6 months: Did you have a sexually transmitted infection?

Yes*	No	Don't Know*

4. Do you have a sexual partner who has HIV? Yes* [ ] No [ ] Don't Know* [ ]

	Yes	No*	Don't Know*
a. If, "Yes, has he or she been on therapy for 6 or more months?			
b. If "Yes," has the therapy suppressed viral load?			

****Consider offering PEP***

5. In the past 3 days: Have you had sex without a condom with someone with HIV who is not on treatment?

Yes**	No	Don't Know

***** ***Consider acute HIV***

6. Have you had a "cold" or "flu" such as sore throat fevers, sweats, swollen glands, mouth ulcers, headache, or rash?

Yes***	No	Don't Know