State of Maryland
DHMH

Maryland Department of Health and Mental Hygiene
Office of Eligibility Services
201 W. Preston St., Room L-9
Baltimore, MD 21201

PATIENT HISTORY
(Information Required by the CDC when filing an HIV/AIDS Case Report)

Name: _____
Last First MI

Medical Assistance Number: _____

Date Submitted by MCO: _____

Please respond to all categories:	Yes	No	Unk
Sex with Male	☐	☐	☐
Sex with Female	☐	☐	☐
Injected Non-Prescription Drugs	☐	☐	☐
Received clotting factor for hemophilia/coagulation disorder	☐	☐	☐

Specify disorder:

☐ Factor VII (Hemophilia A) ☐ Factor IX (Hemophilia B) ☐ Other (Specify): _____

Heterosexual relations with any of the following:	Yes	No	Unk
Intravenous/injection drug user	☐	☐	☐
Bisexual male	☐	☐	☐
Person with hemophilia/coagulation disorder	☐	☐	☐
Transfusion recipient with documented HIV infection	☐	☐	☐
Transplant recipient with documented HIV infection	☐	☐	☐
Person with AIDS or documented HIV infection, risk not specified	☐	☐	☐

	Yes	No	Unk
Received transfusion of blood/blood component (other than clotting factor)	☐	☐	☐

First Last
Month Year Month Year

	Yes	No	Unk
Received Transplant of tissue/organs or artificial insemination (as a primary mode of transmission)	☐	☐	☐

	Yes	No	Unk
Worked in a health-care or clinical laboratory setting (as a primary mode of transmission, documented COPHI)	☐	☐	☐

(Specify Occupation): _____

Revised 6/1/11