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: Recipient (Last) Jane (First) T (MI)

Medical Assistance Number: 01234567890

Date Submitted by MCO: 2/11/11

| **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 Month Year Last 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*