Staff Initials: Site:

1- Gender (circle one): Male Female MTF FTM

2- Age:

3- Zip Code:

4- Race/Ethnicity (circle one): White Black Hispanic Asian Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5- Current living situation (circle one): Homeless Apartment House Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

6- Marital status (circle one): Single Married Cohabitating Divorced Widowed

7- Drugs currently injecting: Heroin Cocaine Heroin/Cocaine Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8- Years of IDU:

9- Injections per day:

10- Do you have health insurance? No Yes, Private Yes, Mass Health

11- Have you seen your primary care provider (PCP) in the past year? No Yes

 If not, please tell us why you didn’t see a PCP (place X next to all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| No insurance coverage |  | Not needed, I’m Healthy |  |
| Unable to afford co-pay |  | Don’t feel comfortable with provider |  |
| No time |  | Scare to see a provider |  |
| Don’t have a provider |  | Other (describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |
| Can’t get to provider’s office |  |  |  |

12- If you have a PCP, does this person know that you use drugs? No Yes

13- Do you and your PCP talk about any of the following?

|  |  |  |
| --- | --- | --- |
| Safer injection technique  | No | Yes |
| Needle exchanges  | No | Yes |
| Intranasal naloxone | No | Yes |
| Overdose prevention  | No | Yes |
| Safer sex education  | No | Yes |
| Drug counseling  | No | Yes |
| PrEP (Pre-exposure prophylaxis)  | No | Yes |
| Testing for Hep B | No | Yes |
| Testing for Hep C | No | Yes |

14- Have you have any recent abscesses or injection related infections? Yes No

If yes, how did you care for the abscess/injection related infection (place X next to all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Took care of it myself |  | Went to the emergency room |  |
| Other non-medical person took care of it |  | Did not treat it |  |
| Went to provider’s office |  | Other (describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |
| Went to urgent care center |  |  |  |

 If yes, how was the abscess/injection related infection treated (place X next to all that apply)

|  |  |  |  |
| --- | --- | --- | --- |
| Warm compress |  | Treated with an antibiotic |  |
| Lanced or opened and drained |  | Other (describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) |  |

15- How often in the past year have you been to an urgent care center for the following disease or illnesses? List the number of times next to each illness/disease listed below

* Injection related infection \_\_\_\_\_\_\_\_\_\_\_
* Mental health issue \_\_\_\_\_\_\_\_\_\_\_
* Accident \_\_\_\_\_\_\_\_\_\_\_
* Illness \_\_\_\_\_\_\_\_\_\_\_
* Present disease or illness got worse \_\_\_\_\_\_\_\_\_\_\_

Other \_\_\_\_\_\_\_\_\_\_\_

16- How often in the past year have you been to the emergency room for the following disease or illnesses? List the number of times next to each illness/disease listed below

* Injection related infection \_\_\_\_\_\_\_\_\_\_\_
* Mental health issue \_\_\_\_\_\_\_\_\_\_\_
* Accident \_\_\_\_\_\_\_\_\_\_\_
* Illness \_\_\_\_\_\_\_\_\_\_\_
* Present disease or illness got worse \_\_\_\_\_\_\_\_\_\_\_
* Overdose \_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_ (describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

17- How many times have you accessed mental health services in the past year? List the number of times next to each option listed below

* In patient hospital psychiatric unit for mental illness \_\_\_\_\_\_\_\_\_\_\_
* In patient hospital psychiatric unit for wanting to hurt yourself \_\_\_\_\_\_\_\_\_\_\_
* In patient hospital psychiatric unit for withdrawal from drugs \_\_\_\_\_\_\_\_\_\_\_
* Out patient hospitalization program \_\_\_\_\_\_\_\_\_\_\_
* Detoxification center \_\_\_\_\_\_\_\_\_\_\_
* Counselor for mental health \_\_\_\_\_\_\_\_\_\_\_
* Other \_\_\_\_\_\_\_\_\_\_\_ (describe:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

18- Is there one place you go or a person you talk to when you are sick or want to get advice about your health?

|  |  |  |
| --- | --- | --- |
| Partner  | No | Yes |
| Friend | No | Yes |
| Family member | No | Yes |
| Provider’s office | No | Yes |
| Needle exchange | No | Yes |
| Other (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_) | No | Yes |

19- In the table below indicate if you have the disease/illness, if you are currently being treated for this in the past year.

|  |  |  |  |
| --- | --- | --- | --- |
|  | No | Yes | # times treated/past year |
| Hypertension | No | Yes |  |
| Diabetes | No | Yes |  |
| Asthma/COPD | No | Yes |  |
| Hepatitis A | No | Yes |  |
| Hepatitis B | No | Yes |  |
| Hepatitis C | No | Yes |  |
| HIV | No | Yes |  |
| Arthritis | No | Yes |  |
| Mental illness | No | Yes |  |
| STI | No | Yes |  |
| Endocarditis | No | Yes |  |

20- Would you come to the needle exchange to receive health care for any of these diseases or illnesses? No Yes

If yes, why would you come?

* I feel comfortable at the needle exchange No Yes
* It would be convenient No Yes
* Other (describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

If no, why would not come?

* I would not feel comfortable at the needle exchange No Yes
* Health care services should only be received in clinics No Yes
* Other (describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_)

21- In the table below, list the last time you were screened for these preventative services?

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Past Year | Past 5 Years | 10 or more years |
| Pap Smear (women) |  |  |  |  |
| Anal pap |  |  |  |  |
| Mammogram (women) |  |  |  |  |
| Colonoscopy |  |  |  |  |
| Cholesterol |  |  |  |  |
| HPV (women) |  |  |  |  |
| TB test |  |  |  |  |

22- Have you received the following vaccines?

|  |  |  |
| --- | --- | --- |
| Flu | No | Yes |
| Pneumovax | No | Yes |
| HPV | No | Yes |
| Hepatitis A | No | Yes |
| Hepatitis B | No | Yes |
| Tetanus  | No | Yes |