PATIENT NOTICE

Our goal at HOPES is to provide quality medical care. Because of our concern for your health and well-being, there are certain types of medications we may not be able to prescribe to you. Examples include the following:

- Oxycontin
- Oxycodone
- Hydrocodone
- Percocet
- Percodan
- Lortab
- Lorcet
- Morphine
- Tylenol #3
- Tylox
- Ultram/Tramadol
- Xanax
- Valium
- Restoril
- Klonopin
- Tranxene
- Ativan
- Ambien
- Soma
- Methadone
- Vicodin
- Stimulants for Adults

If you are already taking any of the above medications, your provider may want to talk to you about alternative treatments.

If you are a new patient, please be aware that it is highly unlikely we will be able to prescribe any of these medications for you.

If you have questions and concerns about this policy, please feel free to discuss them with your provider or with the Chief Medical Officer.

NORTHERN NEVADA HOPES *your partner in health.*

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	
RELEASE OF INFORMATION SIGNED	

Patient Registration

____
DATE

____
LEGAL NAME * FIRST MIDDLE INITIAL LAST

____
OTHER PREFERRED NAME (IF APPLICABLE) PREFERRED PRONOUNS (IF APPLICABLE)

____
HOME ADDRESS CITY STATE ZIP CODE

_________________________ _______________________ __________________________
PHONE NUMBER WORK PHONE NUMBER EMAIL ADDRESS

____
AGE DATE OF BIRTH PLACE OF BIRTH

Have you ever been diagnosed with HIV/AIDS?

☐ Yes ☐ No

Sex at Birth:

☐ Male ☐ Female

Race:

☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American
☐ Native Hawaiian/Pacific Islander ☐ White/Caucasian ☐ Other

Ethnicity:

☐ Hispanic ☐ Non-Hispanic
☐ Other __________________

preferred Language:

☐ English ☐ Spanish **Other** __________________

Marital Status:

☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Legally Separated ☐ Widow/Widower

Employment Status:

☐ Employed ☐ Not Employed ☐ Retired ☐ Active Military Duty ☐ Unknown

Have you been in the military? ☐ Yes ☐ No

Student Status:

☐ Full-Time Student ☐ Part-Time Student ☐ Not a Student

How did you hear about us?

☐ By a current HOPES patient ☐ Advertisement ☐ Internet ☐Social Media ☐ Other_____________

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

Consent to Treatment

I hereby consent to and authorize such treatment as prescribed and fully explained to me by HOPES. I further consent to and authorize such laboratory tests and procedures, x-ray examinations and other routine medical services that are deemed necessary by the HOPES providers. It is not possible to make guarantees concerning the results of the examination for treatment. I acknowledge no such guarantee has been made to me. I understand I will have the opportunity to discuss any and all care and/or treatment proposed to me with the HOPES providers and I may refuse to consent for care and/or treatment if I do not want to proceed with such course of treatment. I will provide HOPES with accurate information regarding my medical, sexual, drug, and/or alcohol history and personal or social concerns which may impact my health or medical care to ensure proper treatment, care, and referral for needed services. I am responsible for having all lab tests, x-rays, and other diagnostic procedures done in a timely manner, prior to my next scheduled clinic appointment, and I will report for all scheduled clinic appointment on time. Hopes does not currently provide Gender Affirming Services or Hormone Replacement Therapy (HRT) Services for individuals under 18 years old. A patient's acceptance of family planning services must not be a prerequisite to eligibility for, or receipt of, any other services, assistance from, or participation in any other program that is offered by Northern Nevada HOPES (42 CFR 59.5(a)(2)).

__________ I will be able to choose a HOPES provider based on availability. I understand that I may be seen by another HOPES provider if my regular provider is unavailable. I understand that if I am late for my appointment, I may not be seen by my scheduled provider. I understand that I must request medication refills by contacting the pharmacy at least three business days prior to my medication supply being exhausted.

__________ I acknowledge that the HOPES Clinic **does not operate an emergency care service**. Staff members are available to me during regular business hours to answer any questions or concerns regarding my need for urgent care. If my situation is an emergency, I will call 911 for assistance or go to the nearest emergency room. If I wish to speak to a provider after hours, I can call the HOPES clinic at (775) 786-4673. I will be directed to the answering service and a provider will return my call.

__________ I understand that HOPES has an integrated team approach to patient management and that medical information may be shared among physicians, Physician Assistants, pharmacists, behavioral health providers, RNs, case managers, medical assistants, trainees, medical students, or interns without consent. This information is used solely for the purpose of coordination of clinical care and social service's needs.

PAYMENT FEES FOR SERVICES

Northern Nevada HOPES provides services to clients who have no third party insurance coverage using a sliding fee scale, adhering to the Health and Human Services Poverty Guidelines. I understand that charges for services are contingent upon my income and can change as my income increases or decreases. In the event that I am entitled to benefits arising out of any policy of private or commercial insurance, said benefits will be applied for and assigned to Northern Nevada HOPES. If I am covered by Medicare, or Medicaid a claim will be sent to the appropriate agency. However, I understand that I am responsible for any copays, deductibles, or other charges required by any insurance policy or government agency and that such copays are payable at the time of rendered services unless other prior arrangements have been made.

I have carefully read and fully understand this consent and agreement. I have received a copy of this consent/agreement and am duly authorized to execute the above, and I accept the terms as described. I understand this consent/agreement is effective until revoked in writing.

____

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

____

SIGNATURE OF HOPES EMPLOYEE **DATE**

NORTHERN NEVADA

HOPES *your partner in health.*

As a patient, you have the right to:

- Be treated with respect and dignity in a safe and private setting.
- Change medical providers at Northern Nevada HOPES.
- Get another opinion about your illness or treatment.
- Respect for your cultural, social, spiritual, and personal values and beliefs.
- Know the cost of your care and ways you may pay for your care.
- Access the on-call provider through an after-hours answering service.
- Access interpretive services if you do not understand English or other assistance if you are hearing or sight impaired. Such services are free of charge.
- Receive services regardless of your ability to pay.
- Be informed about your illness and treatment, including options for your care.
- Know about services available through HOPES.
- Know that HOPES does not provide dental services on site, but you can be referred to external dentists.
- Ask for special arrangements if you have a disability.
- Refuse to be included in any research program without limiting medical care or treatment.
- Be informed that HOPES does not manage chronic pain or provide disability assessments.
- Be informed that taping your office visit with your provider without disclosing the same does not foster a trusting provider-patient relationship.
- Be informed of HOPES's pharmacy hours and timelines for filling new and existing prescriptions.
- Be informed of electronic access of your patient records through HOPES's patient web portal.
- Be assured of privacy of your health records as determined by HIPAA/42 CFR Part 2.
- Know that HOPES has a legal duty to report certain information, and it will make such reports to the proper authorities.
- Refuse treatment care and services as allowed by law.
- File a complaint or a formal grievance if you are not satisfied with the care at HOPES.
- Know about the philosophy and characteristics of the patient management program.
- Have personal health information shared with the patient management program(s) only in accordance with state and federal law.
- Identify HOPES's specific program's staff members, including their job title, and to speak with a staff member's supervisor if requested.
- Speak to a health professional and receive information about the patient management program.
- Receive administrative information regarding changes in, or termination of, the patient management program at HOPES.
- Decline participation, revoke consent, or disenroll as a patient at HOPES at any point in time.

As a patient, you have the responsibility to:

- Inform your medical provider about your illness or problems.
- Ask questions about your illness or care.
- Show respect to HOPES employees, volunteers, and contractors and other patients.
- Understand that physical and/or verbal threats of violence, harassment, coercion, intimidation, and other disruptive behaviors will not be tolerated and could result in terminating the patient-HOPES relationship.
- Cancel or reschedule appointments in advance so that another person may have that timeslot.
- Inform the hospital or ER that you are a patient of HOPES for coordination of care.
- Not arrive at Northern Nevada HOPES or appointments intoxicated or under the influence of drugs.
- Not to arrive at Northern Nevada HOPES or appointments with a weapon of any kind.
- Use medications or medical devices for yourself only.
- Inform a medical provider if you become worse or have an unexpected reaction to a medication.
- Follow prescriber’s directions on all aspects of prescriptions.
- Give written permission to release your health recordswhen necessary.
- Provide HOPES a copy of your living will or durable power of attorney for health care matters.
- Pay your co-pays and bills on time.
- Meet with financial counselors to set up a payment plan if needed.
- Submit forms that are necessary to participate in a program, to the extent required by law.
- Give accurate clinical and contact information and to notify the patient management program of changes in this information.
- Notify your treating provider of their participation in the patient management program, if applicable.

If you have any questions, please ask a HOPES employee.

PATIENT NAME

PATIENT/LEGALGUARDIAN SIGNATURE DATE

If you are or if you become a patient of a substance use (alcohol or other drugs) treatment program at HOPES, your rights also include, but are not limited to, the following:

1. If the program receives funds from the Behavioral Health Certifications for Excellence in Nevada (BHCEN), you have the right to be provided treatment regardless of whether or not you can afford to pay for it, and the program is prohibited from imposing any fee or contract that would be a hardship for you or your family. Northern Nevada HOPES has a sliding fee scale you may qualify for.
2. You have the right to be provided treatment appropriate to your needs.
3. If you are transferred to another treatment provider, you have the right to be given an explanation of the need for such transfer and of the alternatives available, unless such transfer is made due to a medical emergency.
4. You have the right to be informed of all program services that may be of benefit to your treatment.
5. You have the right to have your clinical records forwarded to the receiving program if you are transferred to another treatment program.
6. You have the right to be informed of the name of the person responsible for coordination of your treatment and of the professional qualifications of staff involved in your treatment.
7. You have the right to be informed of your diagnosis, treatment plan, and prognosis.
8. You have the right to be given sufficient information to provide for informed consent to any treatment you are provided. This is to include a description of any significant medical risks, the name of the person responsible for treatment, an estimated cost of treatment, and a description of the alternatives to treatment.
9. You have the right to examine your bill for treatment and to receive an explanation of the bill.
10. You have the right to receive continuous care: To be informed of your appointments for treatment, the names of program staff available for treatment, and of any need for continuing care.
11. You have the right to have any reasonable request for services reasonably satisfied by the program, considering its ability to do so.
12. Waiver of any civil or other right protected by law cannot be required as a condition of program services.
13. You have the right to freedom from emotional, physical, intellectual, or sexual harassment or abuse.
14. You have the right to file a complaint with the State of Nevada if the facility's grievance procedure does not resolve your complaint to your satisfaction, and the right to freedom from retribution or other adverse consequences as the product of filing a complaint. Such complaints regarding treatment of abuse of alcohol or drugs may be addressed in writing or by telephone to: Behavioral Health Certifications for Excellence in Nevada, 4126 Technology Way, 2nd Floor, Carson City, Nevada 89706. Phone: 1-775-684-4190.
15. You have the right to be informed of your rights as a patient. The foregoing are to be posted in the facility in a place where they are immediately available to you, and you are to be informed of these rights and given a listing of them as soon as is practically possible upon you beginning treatment.

I have read, understand, and have been provided a copy of the above Patient's Rights.

PATIENT NAME

PATIENT/LEGALGUARDIAN SIGNATURE DATE

FOR OFFICE USE ONLY: PLEASE CHECK ONE

ADULT PRIMARY CARE	
PEDIATRIC PRIMARY CARE	
ADULT BEHAVIORAL HEALTH	
PEDIATRIC BEHAVIORAL HEALTH	

Notice of Privacy Practice and Complaint/ Grievance Acknowledgement:

NOTICE OF PRIVACY PRACTICE

I hereby acknowledge that I have read or received HOPES Notice of Privacy Practice (or have had it read to me in a language I can understand). I have had all my questions answered about this Notice of Privacy Practice.

I acknowledge that I have been informed that HOPES' Notice of Privacy Practice is located on HOPES' webpage and at each reception area.

I understand that I will receive a paper copy of the Notice of Privacy Practice when I request one.

____I would like a paper copy of HOPES Notice of Privacy Practice

____Individual was provided a paper copy of the Notice of Privacy Practice

COMPLAINTS & GRIEVANCES

Northern Nevada HOPES takes complaints and/or grievances of all kinds seriously and invites discussion with clients or legal guardians about their concerns. HOPES will provide a forum to address complaints, striving for a satisfactory resolution prior to a grievance being filed. In the event a satisfactory resolution is not achieved, a client may file a formal grievance. During the formal grievance process, HOPES strives to work with clients to find mutually satisfying conclusions.

If you would like a copy of the complaint or grievance form with instructions, please contact the Privacy Officer: Julie Gwin, 775-786-4673 ext.2023. ____________

Patient Name: ____

____

SIGNATURE OF PERSON GIVING ACKNOWLEDGEMENT OF LEGAL REPRESENTATIVE **DATE**

PRINT NAME OF PERSON GIVING ACKNOWLEDGEMENT ________________________________

RELATIONSHIP TO INDIVIDUAL: ___Self ___Parent ___Guardian ___Authorized Representative

Acknowledgement Refused

On this date, the undersigned patient refused or failed to acknowledge receipt of the Notice of Privacy Practice and Complaints/Grievances.

Patient Name:____ Date:______________

Reason for refusal/failure: ____

____

____

____

A signed copy of this page is to be filed with the patient's record.

NORTHERN NEVADA HOPES *your partner in health.*

Email Consent: Non-Secure E-Mail/Text (SMS) Messaging

____
PATIENT NAME DATE OF BIRTH

____
PATIENT EMAIL ADDRESS

Northern Nevada HOPES' team cannot guarantee the security and confidentiality of an e-mail or text (SMS) message transmission. Employers and online services have the right to access and archive e-mail and text (SMS) transmitted through their systems. If your e-mail is a family address, other family members may see your messages. If you allow others access to your cell phone they may see your messages. Therefore, please be aware that you e-mail and/or text (SMS) at your own risk. Because of the many internet and e-mail factors beyond our control, we cannot be responsible for misaddressed, misdelivered or interrupted e-mail or text (SMS) messages. Northern Nevada HOPES and your health care provider are not liable for breaches of confidentiality caused by yourself or a third party.

Northern Nevada HOPES will only send text (SMS) messages pursuant to the Federal Communications Commission's (FCC) Declaratory Ruling and Order. HOPES will not receive text (SMS) messages.

E-mail is best suited for routine matters and simple questions. You should not send e-mail for urgent or emergency situations or for matters requiring an immediate response. Your provider will attempt to read and respond promptly to e-mail, but cannot guarantee that an e-mail will be read and responded to within any particular period of time. Time sensitive issues should be taken care of by telephone.

Please do not use e-mail for communications regarding sensitive health information, such as sexually transmitted diseases, AIDS/HIV, mental health or substance abuse.

Please include your full name, birthdate and telephone number in all e-mails. List the subject of your e-mail in the "Subject" line of your message.

All e-mails between you and your provider regarding diagnosis or treatment will be printed and made part of your permanent health record. Your provider may forward your e-mail to other staff members as necessary for response. However, your e-mail will not be forwarded outside the Health Team without your authorization. In order to prevent the introduction of computer viruses into our system, do not send attachments to us in your e-mail.

You are responsible for protecting your password or other means of access to e-mail and text (SMS) messages.

____
SIGNATURE OF PATIENT DATE

____
SIGNATURE OF HOPES EMPLOYEE DATE

Patient Financial Responsibility Acknowledgment

As a patient of Northern Nevada HOPES, it is important that you understand and agree to the following:

- I agree to provide accurate and up-to-date insurance information at the time of service and to notify the clinic of any changes.
- I understand that services rendered to me by Northern Nevada HOPES may not be fully covered by my insurance plan.
- I acknowledge that I may be responsible for all or a portion of charges for services I receive at Northern Nevada HOPES if they are not covered by my insurance. This may also include deductibles, copayments, and coinsurance depending on the requirements of my insurance plan.
- In the event I am unable to pay for all or a portion of the charges that are not covered by insurance, that are due after applying insurance, or if my insurance is not valid for the services received, I understand that I can request to be assessed for a sliding-fee scale based on my income or establish a payment plan.

I have read, understand, and agree to the terms of this Patient Financial Responsibility Acknowledgment.

Patient Name: ________________________________ **Signature:** ______________________________________

Date: ____________________

Acreditación de Responsabilidad Financiera del Paciente

Como paciente de Northern Nevada HOPES, es importante que comprenda y acepte lo siguiente:

- Estoy de acuerdo en proporcionar información de seguro precisa y actualizada en el momento del servicio y en notificar a la clínica sobre cualquier cambio.
- Entiendo que los servicios prestados a mí por Northern Nevada HOPES pueden no estar completamente cubiertos por mi plan de seguro.
- Reconozco que puedo ser responsable de la totalidad o de una parte de los cargos por los servicios que reciba en Northern Nevada HOPES si no están cubiertos por mi seguro. Esto también puede incluir deducibles, copagos y coseguro, dependiendo de los requisitos de mi plan de seguro.
- En caso de que no pueda pagar la totalidad o una parte de los cargos que no están cubiertos por el seguro, que son debidos después de aplicar el seguro, o si mi seguro no es válido para los servicios recibidos, entiendo que puedo solicitar una evaluación para una escala de tarifas móviles basada en mis ingresos o establecer un plan de pago

He leído, entiendo y acepto los términos de este Reconocimiento de Responsabilidad Financiera del Paciente.

Nombre del Paciente: ________________________________ **Firma:** ______________________________________

Fecha: ____________________

ACCT # ________________

2026 NORTHERN NEVADA HOPES FPL SURVEY

ANNUAL INCOME

To share your annual income, please fill in the Family Size box with the number of people in your household. Then, choose the box that corresponds to the dollar amount closest to your annual household income. For example, if your household consists of 5 people with no income, select the box with an annual income ranging from $0-$15,960.

INGRESOS ANUALES

Por favor comparta sus ganancias anuales. Primero, escriba la cantidad de personas en su hogar en la casilla de tamaño de familia. Luego, seleccione la casilla correspondiente al monto en dólares más cercano a su ingreso familiar anual. Por ejemplo, si su hogar está formado por 5 personas sin ingresos, elija la casilla de ingresos anuales de $0-$15,960.

Family Size/ Tamaño de Familia	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales	Annual Gross/ Ingresos Anuales
	$0 - $15,960 ☐	$27,051 - $34,150 ☐	$41,251 - $48,350 ☐	$55,451– 62,550 ☐	$69,651 - $76,750 ☐	$83,851 - $90,950 ☐	$98,051 -$112,250 ☐
	$15,961 - $27,050 ☐	$34,151 - $41,250 ☐	$48,351 - $55,450 ☐	$62,551-$69,650 ☐	$76,751 – $83,850 ☐	$90,951 - $98,050 ☐	$112,251 above/ más ☐

Name/Nombre: ____ **Date/Fecha**: ____________

Name/Nombre

Revised 1/29/2026

NORTHERN NEVADA HOPES

No-Show Policy

1. No-Show Policy:

A patient who misses 3 consecutive medical appointments without providing prior notification will be required to have 1 walk-in or same-day visit before being able to schedule appointments again.

Exceptions:

Emergencies: In the case of a medical emergency, the patient will not be penalized for missing an appointment.

Valid Reasons: If the patient can provide a valid reason for missing an appointment, such as a serious illness, family emergency, or transportation issues, they may be exempt from the policy.

Communication:

Patients will be notified of this policy at the time of their initial visit and whenever their appointment status changes. Staff will make every effort to contact patients to confirm appointments and address any concerns.

Política de no Presentarse

1. Política de no presentarse:

Un paciente que falte a tres citas programadas sin proporcionar notificación previa tendrá que tener una visita sin cita previa antes de poder programar citas nuevamente.

Excepciones:

Emergencias: En caso de emergencia médica, el paciente no será penalizado por faltar una cita.

Razones válidas de: Si el paciente puede proporcionar una razón válida para faltar una cita, como una enfermedad grave, emergencia familiar o problemas de transporte, puede estar exento de la póliza.

Comunicación:

Los pacientes serán notificados de esta política en el momento de su visita inicial y siempre que cambie el estado de su cita. El personal hará todo lo posible para contactar a los pacientes para confirmar las citas y abordar cualquier inquietud.

NORTHERN NEVADA HOPES your partner in health.

Adult Health History | New Patient

Today's Date____________________

____

LEGAL NAME PREFERRED NAME FORMER NAME(S) Date of Birth

Previous Primary Care Provider? ________________________________ Last visit? ___________________

MEDICATIONS:

☐ I take no medications

Please list all prescriptions *and* non-prescription medications; vitamins, home remedies, supplements, herbs, etc.

MEDICATION	STRENGTH (mg)	TIMES PER DAY	REASON FOR TAKING MED

Any allergies or intolerance to medications, foods or latex (include the type of reaction)?:

☐ I have no allergies

____

____

____

Please list the dates and location(s) of your most recent Preventative Care Screenings:

Mammogram ________________________________Colon cancer screening __________________________

HIV Test ___________________________________Pap smear _____________________________________

NORTHERN NEVADA HOPES *your partner in health.*

PERSONAL MEDICAL HISTORY: Do you have (now) or have you had (past) any of the following conditions? ☐ NONE

CONDITION	NOW	PAST	COMMENTS/SPECIALISTS SEEN
Autoimmune disorders (Rheumatoid arthritis, Lupus, etc.)			
Blood Clot (leg or lung)			
Cancer			
Coronary Artery Disease/Heart Attack			
Diabetes (adult or childhood)			
GI Issues (heartburn, colon polyps, diverticulosis, etc.)			
Hepatitis A, B, or C			
High Blood Pressure			
High Cholesterol			
HIV/AIDS			
Kidney Disease/Failure, Kidney Stones			
Mental illness (depression, anxiety, bipolar etc.)			
Osteoporosis			
Respiratory Conditions (Asthma, Sleep Apnea, COPD)			
Seizure/Epilepsy			
Sexually transmitted infections			
Skin Conditions (Eczema, psoriasis, etc.)			
Stroke			
Substance Use Disorder (opioids, meth, alcohol, etc.)			
Thyroid disorders			
Other (list)			

GYNECOLOGIC HISTORY	OBSTETRIC HISTORY
Are you having a period every month?	How many times have you been pregnant?
Heavy, light, or normal flow?	How many live births?
Date of last period?	Abortions?
History of abnormal pap?	Miscarriages?
What are you using for birth control?	# of c-sections?
Age at beginning periods?	# of vaginal deliveries?
Age at ending periods?	Pregnancy or Delivery complications?

NORTHERN NEVADA HOPES *your partner in health.*

HOSPITALIZATIONS: Please list overnight hospitalizations, date of hospitalization and which hospital:

____
____
____

PROCEDURES/SURGICAL HISTORY: Please list type of surgery, date of surgery and which hospital:

____
____
____

FAMILY HISTORY: Do you have a family history (parents, grandparents, siblings) of any of the following? If yes, please check box

☐ Diabetes
☐ High Blood Pressure
☐ Coronary Artery Disease/Heart Attack
☐ Mental Illness/Substance Abuse
☐ Cancer
☐ Stroke
☐ Other

Please explain any boxes you checked:

____
____
____

Adopted? ☐ Yes ☐ No

SOCIAL HISTORY

Marital status (please check one):

☐ Single ☐ Partner ☐ Married ☐ Divorced ☐ Widowed ☐ Other __________________

Who lives at home with you? ____

Occupation and Employer?

____

Highest Level of Education? ____

Are you currently housed? ☐ Yes ☐ No

BEHAVIORAL HEALTH

Would you like to speak to a behavioral health provider today, if available? ☐ Yes ☐ No

Do you feel safe in your home? ☐ Yes ☐ No

Have you ever been physically, emotionally, or verbally abused by your partner or anyone else?
☐ Yes ☐ No

NORTHERN NEVADA HOPES *your partner in health.*

Nicotine Use

☐ Current cigarette use: _____ packs per day Start date ________

☐ Past cigarette use: _____ packs per day Quit date ________ # of years smoked ________

☐ Other nicotine use: ☐ Pipe ☐ Cigar ☐ Vape ☐ Chew

☐ Never cigarette use

Alcohol Use

Do you drink alcohol? ☐ current ☐ past ☐ never Number of drinks per week ________________

Drug Use

Marijuana: ☐ current ☐ past ☐ never Recreational drugs: ☐ current ☐ past ☐ never

IV drug use: ☐ current ☐ past ☐ never

Sexual Health

Have you had sex in the past 12 months? ☐ Yes ☐ No

Sexual partners have been: ☐ Male ☐ Female

Do you think of yourself as (circle all that apply):

Straight/heterosexual Lesbian, gay or homosexual Bisexual Don't know or undefined Other

Gender Identity

What is your current gender identity?

☐ Male ☐ Female ☐ Transgender Male (female to male) ☐ Transgender Female (male to female)

☐ Gender Queer, neither exclusively male or female

☐ Other ____

What are your preferred pronouns? ____

What sex were you assigned at birth? ☐ Male ☐ Female