

Personal Information Sheet (DOH-NEC Form A)

Please read Basic information at the back of this form. All information given will be strictly confidential. Please fill out form as honestly as possible. If below 18 years old, or physically/mentally incapacitated, the guardian is requested to fill out this form on behalf of the individual/client.

I. Purpose of Testing (Please check only one box)

- | | | |
|----------------------------------|------------------------------|-----------------------------|
| Personal | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Employment | | |
| Local | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Abroad | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Legal/Insurance | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Entrance to School | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If others, Please specify: _____ | | |

II. Demographics (Please fill up all information asked:)

<input type="text"/>	<input type="text"/>	<input type="text"/>
First Name	MI	Last name
Permanent address/ mailing address: _____		
Contact No: _____		
Birthday(MM/DD/YYYY): ___/___/_____ Sex (M/F): ___ Age: _____ Civil Status: _____		
No. of Children (if applicable): _____ Nationality: _____		

III. Employment History (Answer as honestly as possible)

Present Occupation: _____
 Occupation/s in the last 5 years: _____

IV. Travel History (Answer as honestly as possible)

Travel abroad in the past 5 years: Yes No
 If yes, What country/countries: _____

Purpose of travel abroad:

<input type="checkbox"/> Tourist	<input type="checkbox"/> Education/Training
<input type="checkbox"/> Business/Official	<input type="checkbox"/> Employment
If OFW, <input type="checkbox"/> Sea-Based	<input type="checkbox"/> Land-Based

(Please check box/es that apply)

V. History of HIV Test

Previous HIV Test? Yes No
 If Yes, where (Fill out applicable information)

Name of Hospital: _____	Date: _____	Result(+/-): ___
Name of Clinic: _____	Date: _____	Result(+/-): ___
Name of Blood Bank: _____	Date: _____	Result(+/-): ___

VI. Have you experienced any of this? (check all that applies)

Multiple Sex Partners Yes No
 If Yes, Sex with opposite sex Sex with both male/female Sex with same gender

Injecting drugs without doctor's advice
 Born to HIV infected mother
 Current or Previous Syphilis, gonorrhoea, genital discharge, genital ulcer

Surgery Date: (Year) _____ Country: _____
 Blood Transfusion Date: (Year) _____ Country: _____

VII. Did you receive information on HIV/AIDS in these facility? Yes No

If yes, please check all that applies

- | | |
|--|--|
| <input type="checkbox"/> How a person can get HIV | <input type="checkbox"/> What to do if HIV screening is reactive |
| <input type="checkbox"/> Services Available (counseling, treatment care & support) | <input type="checkbox"/> What to do if HIV confirmatory test is positive |

VIII. What are your other sources of information on HIV/AIDS (check all that applies)

- | | |
|---|---|
| <input type="checkbox"/> One on One Counseling | <input type="checkbox"/> Group Counseling |
| <input type="checkbox"/> Pre-Departure Orientation Seminar (PDOS) | <input type="checkbox"/> Video |
| <input type="checkbox"/> Pamphlets/Posters | <input type="checkbox"/> Other, Please specify: _____ |

IX. FOR PHYSICIANS ONLY

Name of Agency/Hospital/Clinic/Lab: _____
 Address: _____

Name and Signature of MD: _____
 Contact No.: _____