Health & Mental Health Services
Audre Lorde Health Program

Los Angeles LGBT Center

AUDRE LORDE SUPPLEMENTAL QUESTIONNAIRE AND STATEMENT

Please complete all sections unless otherwise indicated

Today's date / /	**Please Note:** To help your health care provider better care for your individual needs, consider the questions below and answer them to the best of your ability. If any question makes you uncomfortable or does not apply, skip it and move onto the next.	

(Please print clearly)

How do you identify (check all that apply):

___ Female ___ Transsexual ___ Genderqueer
___ Male ___ MTF ___ Intersex
___ Transgender ___ FTM ___ Other: _____
___Skip

___ Lesbian ___ Bisexual ___ Queer
___ Gay ___ Heterosexual ___ Other: _____
___Skip

Please briefly describe the reason(s) for your visit today.

_____

_____

_____

When was the last time you saw a health care provider? _____/_____ (month/year)

Name of health care provider: _____

Location of health care provider: _____

Have you ever had a pap smear? ___ Yes ___ No

If yes, please estimate the month and year: _____/_____ (month/year)

If yes, have you ever been told your results were abnormal?: _____

Have you ever had a breast exam from a health care professional? ___ Yes ___ No

If yes, please estimate the month and year: _____/_____ (month/year)

Please list any significant medical or mental health conditions you have.

_____

_____

_____

Please list any medications you are taking/have taken.

_____

_____

_____

Over the last two weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious, or on edge				
Feeling down, depressed, or hopeless				
Not being able to stop or control worrying				
Little interest or pleasure in doing things				

How difficult have those problems made it for you to do your work, take care of things at home, or get along with other people??

___ Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult

___ I have not experienced any of the problems mentioned above

The next few questions ask about things that you may have experienced in current or past relationships.

	No	Yes	I don't feel comfortable answering		
Have you ever been emotionally or physically abused by your partner or someone important to you?					
Within the last year, have you ever been hit, slapped, kicked, or otherwise physically hurt by someone?					
Within the last year, has anyone forced you to have sexual activities?					

Do any of the following apply to you, either currently or in the past?

	No	Yes	I don't feel comfortable answering
Overnight mental health care			
With holding food from yourself, making yourself throw up after eating too much			
PTSD, extreme stress, unable to stop thinking about a past traumatic event			
Suicide planning/attempts			
Self-harm (cutting, burning, etc)			
Sexual violence			
Emotional or physical harm from someone important to you (a partner, a parent, etc)			

Do you currently smoke cigarettes? ___ Yes ___ No

If yes, how many cigarettes per day? ___ 10 or less ___ 11 to 20 ___ 21 to 30 ___ 30 or more ___ not daily

Do you currently drink alcohol? ___ Yes ___ No

If you drink alcohol, how many days have you had 4 or more drinks in the last month? ____ (number of days)

Have you used any of the following substances in the last year? Please check all that apply.

	No	Yes	If yes, before/ during sex?
Ecstasy/MDMA/X/Molly			
Mushrooms			
Marijuana			
Prescription drugs used without prescription (OxyContin, Valium, Xanax, Percocet, Vicodin, etc.)			
Methamphetamine			
Heroin			
Other (LSD, Ketamine, GHB, etc.)			

Do you feel like you have adequate social support? ___ Yes ___ No

Please describe your social support systems.

_____

_____

Would you be interested in discussing any of the following issues with our staff?

___ Money/Finances ___ Employment ___ Food resources ___ Housing or homelessness

___ Relationship problems ___ Immigration ___ Alcohol or substance use ___ Legal concerns

___ Partner abuse/violence ___ Sexual Health/STDs/HIV ___ Other (please specify) _____

Is there anything else you would like to discuss with your medical provider or counselor today? Please specify below.

_____

_____

_____

For Los Angeles LGBT Center Employee Use Only:

_____ _____ _____

Staff Signature Title Date

AUDRE LORDE SUPPLEMENTAL QUESTIONNAIRE AND STATEMENT

Name:

PF#: