Case Discussions

National HIV Curriculum Podcast

Initial Visit & Evaluation for a Person with HIV

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Season 2, Episode 2

National HIV Curriculum Podcast editors Dr. Jehan Budak and Dr. Aley Kalapila discuss their approaches and key questions they ask during an initial visit and evaluation with a person who's new to their clinic.

Topics:

- OIs and HIV
- medical history
- U=U
- ART
- HIV Prevention

Jehan Z. Budak, MD
Associate Professor of Medicine
Division of Allergy & Infectious Diseases
University of Washington

Disclosures

Disclosures for Jehan Z. Budak, MD
None

Aley G. Kalapila, MD, PhD
Professor of Medicine
Division of Infectious Diseases
Emory University School of Medicine
Grady Health System

Disclosures

Disclosures for Aley G. Kalapila, MD, PhD
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Transcript

Read along with the audio or jump to a particular chapter.

In this episode:

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intro--initial-visit**[00:00] Intro & Initial Visit**

Hello, everyone. I'm Dr. Jehan Budak from the University of Washington in Seattle, and welcome to the National HIV Curriculum Podcast. This podcast is intended for health care professionals who are interested in learning more about the diagnosis, management, and prevention of HIV.

I'm back with my colleague, Aley Kalapila, an ID physician at Emory University in Atlanta. Hi Aley!

Dr. Kalapila

Hi Jehan. Hi everyone, looking forward to this episode.

Dr. Budak

Today, we're going to discuss the evaluation of a person who's new to the clinic and establishing care for HIV management and other primary care needs. Now, as a bit of background, there are two resources that I use: the HHS [U.S. Department of Health and Human Services] antiretroviral guidelines and the HIVMA-IDSA [HIV Medicine Association of the Infectious Diseases Society of America] HIV primary care guidance that have recommendations for what to include in the baseline initial evaluation of a person with HIV, and we recommend reviewing those.

The initial visit and evaluation can be a complex experience for the patient, and includes not only a medical aspect, but a tremendously important psychosocial aspect as well, especially if it's a new diagnosis. So, for the purposes of this episode, we want to have us primarily focus on the medical aspects of the evaluation. And before we even launch into that, Aley, I want to first get your thoughts on how you open your visit with a new patient.

Dr. Kalapila

Sure, so you know, I typically start with a check-in with the patient to see how they're doing emotionally given that this is a new diagnosis of HIV infection, and we really want to know how we can best support them. I also use the first several minutes of the visit to find out a little bit more about the patient, and try to get to know them a little bit better. I also ask them about specific questions or concerns that they have, and I make note of this to address them during the course of the visit. So really, what I'm trying to do is give them the emotional support that they need, and also figure out what is most important to them to address during the course of the visit.

Dr. Budak

Absolutely, I'm on the same page as you. And, probably the most important goal at this initial visit, whether a new diagnosis or not, is to establish a good rapport with the individual and make them feel welcome, accepted, seen, and to do everything that's in our power to increase the chances of them returning to clinic to see us again, which is probably the biggest predictor of outcome. So, any other key things you mention at the start of your visit?

Dr. Kalapila

I also really do talk about how far we have come with HIV medications, especially with regard to reducing pill burden, and also with lowering toxicity and side effects. I talk about the fact that HIV is no longer a life-limiting diagnosis because of the effectiveness of these medications. And I really make it a point to let them know that my main goal at the end of my visit with them is to initiate antiretroviral therapy, ideally on the same day of their visit with me or as soon as possible.

Dr. Budak

Totally! We have a lot of data, a *lot* of data from both domestic and international randomized controlled studies and cohort studies, that show the advantages in HIV care with rapid ART [antiretroviral therapy] initiation, including but not limited to improvement in linkage to care, retention in care, reduced time to viral suppression, and improved long-term viral suppression. And in fact, the HHS (or Department of Health & Human Services) recommends rapid ART initiation. I mean, that being said, recommending rapid ART initiation, it's important that we acknowledge that one of the main barriers to rapid ART starts are the systems-level hurdles that we all encounter. To getting patients enrolled in insurance or medication assistance programs, etcetera, so that they can even access ART that they need.

hiv-specific-medical-history**[03:30] HIV-Specific Medical History**

Dr. Budak

And so, now that we've discussed some of the ways in which we start our conversation with the patient and try to establish a rapport, I'd like to delve into the medical aspects of an HIV-specific medical history, recognizing that everyone may organize their initial visit differently. So, when you meet the patient for the first time, what sort of information are you hoping to gather?

Dr. Kalapila

First, I start with my HPI (or history of present illness). And, in this case, what I do is I ask about the context in which they were diagnosed. And by that I mean, when and how did they get diagnosed? How long have they been aware of their diagnosis? Were they hospitalized with any severe HIV-associated illnesses? Or, did they find out they had HIV after routine testing at a health fair, for instance, or because they came in to their primary care doctor's office and they got diagnosed with an STI [sexually transmitted infection], which prompted HIV testing? I also ask if they ever felt unwell or were they asymptomatic at the time of their diagnosis. Because, if they tell me, for example, that they had felt quite unwell and they were hospitalized with an opportunistic infection, then that's really important information, because now I can assume that they have a CD4 count that's less than 200.

Dr. Budak

And I think another thing to ascertain is, if they've ever been tested for HIV before this time, and if so, how long ago was their last HIV test. I use this information to help kind of gauge or estimate how long a person may have had HIV, and then how likely it is that they have severe immunosuppression. So, for example, if someone said they had a negative HIV test a year ago, it's likely that they still have a pretty high CD4 cell count. But, on the other hand, if someone had testing several years ago and then was out of care and not on meds, and I might expect that their CD4 count would be low.

Dr. Kalapila

Yes, you know, totally agree. And so, once I've established the context in which their HIV was diagnosed, I then ask about risk factors for HIV acquisition, so that at some point during this visit, I can discuss HIV prevention strategies within their sexual and social networks.

art-history--adherence**[05:31] ART History & Adherence**

Dr. Budak

Great point, and I'll bring us back to talking about prevention strategies a little bit later in this episode. But, for now, let me ask: You've told us a lot of the questions you'll ask if this is a new diagnosis, but if this was not a new diagnosis, how would your questions be different, if at all?

Dr. Kalapila

Yes, in addition to all the questions I've mentioned, I also would want to know what antiretrovirals, if any, they had taken any previously. So, if they had taken ART before, I will also ask them if they took their meds regularly, or if they stretched their supply out, or did they partially-dose their medications? And, if they weren't taking their meds consistently, then how frequently were they taking them? What were the barriers to adherence that they might have had? And, I really want to know this because when I'm trying to determine a treatment plan, I want to make sure I'm addressing these barriers to set the patient up for success.

Dr. Budak

And I think what you're sort of getting at with these questions about adherence as well is if the person might have had periods of nonadherence or suboptimal adherence, and might have developed HIV drug resistance during those times. As we know, there are certain ARTs like efavirenz, rilpivirine, or cobicistat-boosted elvitegravir, that have low barriers to resistance, and thus, partial adherence to them, especially for long periods of time, could raise the risk of developing mutations. And then, depending on which class of medication they were inconsistently taking, you might want to avoid that class when choosing an ART regimen, especially for treatment-experienced individuals.

review-systems**[07:01] Review of Systems**

Dr. Kalapila

Exactly. So, with that, I think we've covered a lot of the questions that I would ask in an HPI [history of present illness] and so, after this, I move on to the review of systems. A thorough review of systems is extremely important because many individuals with a low CD4 count can have very mild symptoms of opportunistic infections or AIDS-associated malignancies. It is especially important to assess for any neurological symptoms that include changes in vision, hearing, headaches, or stroke-like features. Anything else that you'd want to add here, Jehan, to review systems?

Dr. Budak

No**,** I don't think so. I think you got all the key points, and I think, as you mentioned, the important thing for listeners to remember is that infections and malignancies in individuals with low CD4 cell counts can often have very subtle presentations.

Dr. Kalapila

Exactly. So, for example, if someone with a low CD4 count had neurological symptoms, especially headaches, then antiretroviral therapy may need to be delayed until cryptococcal disease has been ruled out.

medical--family-history**[08:00] Medical & Family History**

Dr. Budak

So, after a thorough review of systems is obtained, let's talk about past medical history. What are you

specifically asking about?

Dr. Kalapila

So, I like to use open-ended questions about their past medical conditions and prior surgical history. And then, I also specifically ask about any prior pregnancies or any pregnancy-related complications. I do inquire about prior sexually transmitted infections, including what STIs and also any treatment that they may have received for them. And I also ask about history of prior tuberculosis or latent TB infection, and prior hospitalizations, especially those related to HIV. Anything else that I'm missing?

Dr. Budak

No, I don't think so, and moving on to family history, I try to ask about chronic medical conditions amongst family members, especially amongst first-degree relatives because this can help inform routine primary care and health prevention, such as cancer screening for the patient. And, this is also especially important since so many people with HIV are living longer and aging. And then, Aley, you just mentioned TB, and we're in the family history section now, and actually, I think it's important to ask about any relatives who may have had TB or really, actually, any close contacts.

Dr. Kalapila

Great. So, I think that sort of gets us through our HPI, and, now, past medical history, and makes you realize just how much primary care we actually do when we take care of our patients with HIV infection.

medications--allergies**[09:23] Medications & Allergies**

Dr. Kalapila

So, after that, the next thing I do is actually review medications. So, I always inquire, of course, about antiretrovirals, but also about other medications that the patient is taking. And when I do this, I'm always at the back of my mind thinking about potential drug interactions between antiretrovirals and any other medicines that the patient is taking. And if I'm in any doubt, I use a variety of resources. I often check with my clinical pharmacist. I also refer to the HHS antiretroviral guidelines. Also, the University of Liverpool has a fantastic website to look for drug interactions between antiretrovirals and other medications.

Dr. Budak

I love that interaction checker and I use it all the time. And, I'm sure another question you ask about specifically is if the patient had been taking or has ever had prior use of HIV PrEP (or preexposure prophylaxis)?

Dr. Kalapila

Oh, absolutely! This is an extremely important and very specific question that we have to ask because it can impact the antiretrovirals that we would consider prescribing for the patient. So, after asking, of course, about other medicines and prior HIV PrEP use, I also think it is incredibly important to clarify about any specific medication allergies, especially to antimicrobials. And if so, if the patient says that they have an allergy to antibiotics, then I ask them what sort of reaction they might have had. So, was it a historical allergy, that is, did their parents tell them that they had this allergy as a child? Or, did they actually have a recent allergic reaction to a medication? For example, you know many patients say that they have an allergy to penicillin, but then when you go back and dig in their history you find that they might have received a beta-lactim for STI treatment, or received amoxicillin or a cephalosporin, for instance, at a dentist's office.

Dr. Budak

Definitely.

other-questions**[11:13] Other Questions**

Dr. Budak

What about social history?

Dr. Kalapila

In addition to sort of getting a general social history, this is a great time to get information on sexual history, tobacco use, substance use history. This is another time when I ask about TB exposure history, which can include prior stay in an institutionalized group setting, such as shelters, jails, prisons, or a history of spending any significant amount of time in TB endemic areas or countries. And, also, if they've ever screened positive for latent TB infection.

Dr. Budak

And then, I also take time in the social history, unless I've already talked about it in the HPI, to explore what sort of social support the patient has, as you know this can have implications on their ability to remain adherent to meds and their treatment plan. And then, I also ask if they've informed anyone else of their HIV diagnosis.

Dr. Kalapila

Yes, this is all pertinent information about the patient's social support and social network, and really kind of segues into a great opportunity to discuss HIV prevention practices and harm reduction strategies with the patient.

hiv-prevention**[12:17] HIV Prevention**

Dr. Budak

So, there're a lot of different HIV prevention strategies, and what one decides to discuss should be tailored to the individual. So, Aley, why don't we start off with HIV Treatment as Prevention?

Dr. Kalapila

Great! So, that's usually what I start with, actually. So, Treatment as Prevention means that if a patient with HIV is on antiretroviral therapy and they maintain an HIV RNA level less than 200 copies, then their risk of sexual transmission to an individual who is HIV seronegative is essentially zero. And, we know this based on many, many excellent clinical trials and real-world data involving sexual transmission, and, of course, we now refer to this concept as U=U (or undetectable equals untransmittable).

Dr. Budak

I love talking about U=U and taking that opportunity with patients. And, I actually talk about U=U with patients, whether or not they bring a partner into the visit. So, let me actually take this opportunity to ask, Aley, what's your approach to counseling if the patient has brought their partner into the visit, and/or are in the room with you?

Dr. Kalapila

Yeah, that scenario happens to me fairly often. So, if a patient brings in their partner, the first thing I do is to

make sure is that the partner has been tested. If they have not been tested for HIV, then I make sure that I refer them to HIV testing resources. I also ask the partner when their last sexual encounter was because if they've had condomless sex within the prior 72 hours, then the partner may need to be started on PEP (or post-exposure prophylaxis), which, as you and I both know, is an extremely effective modality for HIV prevention for seronegative individuals, provided it's being used within 72 hours of possible exposure to HIV.

Dr. Budak

PEP is also effective for individuals who had a potential exposure not just through sex, but rather through a percutaneous exposure, such as through shared injection drug equipment or through an occupational exposure.

So, Aley, back to this scenario where if the patient brings in their partner and you know that the partner is seronegative, do you discuss PrEP?

Dr. Kalapila

Absolutely. So, we know that oral PrEP—so that's either tenofovir disoproxil fumarate combined with emtricitabine or tenofovir alafenamide plus emtricitabine, as well as injectable PrEP—so this is intramuscular cabotegravir, which has been FDA-approved already or subcutaneous lenacapavir, which hopefully should be approved for PrEP in the near future by the FDA. So, we know that both oral and injectable PrEP can be used as an effective mode of HIV prevention if taken by a seronegative individual who is at risk for acquiring HIV. So, yes, I do use this visit as an opportunity to counsel patients' partners by informing them about PrEP and also, really, discussing access to PrEP, whether it's in my clinic or at another location.

Dr. Budak

And how about any specific counseling for individuals who acquired HIV due to substance use?

Dr. Kalapila

So, you know, for individuals with injection use, I will try to refer them to local syringe service programs to reduce their risk of HIV transmission to other individuals within the patient circle, who may also be at risk. And if the patient has opioid use disorder, I would use this as an opportunity in the visit to discuss medication-assisted therapy, using either buprenorphine or methadone.

Dr. Budak

I do the same and discuss other harm reduction strategies, including use of nasal naloxone spray for reversal of opioid overdose. And I also want to add that this is also the time to discuss with patients whether anyone else within their social or sexual network needs to come in for testing.

So, Aley, I think with all of that we've addressed most of the salient points when doing an initial evaluation for an individual with HIV, and we'll pick back up in a future episode to talk about the initial laboratory evaluation for a person with HIV.

Dr. Kalapila

Thanks, Jehan, looking forward to the next episode. Bye!

credits**[16:07] Credits**

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