TEXAS Department of State Health Services
TX DSHS Public Health Nursing

STD History and Physical Assessment

Date of Service:

Patient Demographics

Last Name	First Name	Middle Initial	Pref. name/AKA/pronoun	Date of Birth

Sex (at birth): ☐ Female ☐ Male

Gender (all that apply): ☐ Female ☐ Male ☐ Transgender ☐ Self Define: | Pref. Pronoun:

Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ African American ☐ Hawaiian/Pacific Islander ☐ White ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic

Street Address	City	State	Zip	County

Home Telephone	Cell Phone	Vitals:	Temp:	Pulse:	RR:	BP:

Referral Source:

Reason for Visit

Yes	No	Reason
☐	☐	Patient has genital lesions, genital discharge, or other symptoms suggestive of a sexually transmitted disease
☐	☐	Patient has partner with genital lesions, genital discharge, or other symptoms suggestive of a sexually transmitted disease
☐	☐	Patient has partner treated for a sexually transmitted disease
☐	☐	Patient referred by local or state DIS. Review labs and refer to appropriate STD treatment SDO
☐	☐	Patient requesting STD testing – denies reasons listed above

If patient seen within past 30 days:

Patient has persistent symptoms? ☐ Yes ☐ No

If Yes, was partner treated? ☐ Yes ☐ No ☐ Unknown

If Yes, treatment:

(see contact sheet for partner names)

Partner Sx/Sx Onset Date

Partner Dx/Dx Date

Risk Assessment (check all that apply)

Sexual activities ☐ Men ☐ Women ☐ Trans

#Sex partners /60 days: #Male:_____ #Female:_____ #Trans:_____

Sites of Exposure in the last 60 days

☐ Penis ☐ Oral: ☐ Give ☐ Receive

☐ Vagina ☐ Rectal: ☐ Give ☐ Receive

Last Sexual Contact (date): _____

Yes	No	**Have you ever?**
☐	☐	Had sex with someone you just met?
☐	☐	Had sex with men in public place?
☐	☐	Condom Use: ☐ Always ☐ Sometimes ☐ Never
☐	☐	Traded sex for money or drugs?
☐	☐	Had sex with an IV drug user?
☐	☐	Had sex with a HIV(+) partner?
☐	☐	Used drugs? ☐ IV ☐ Non IV
☐	☐	Shared needles?
☐	☐	Used social media, Apps or the internet to find sex partners?
☐	☐	Been forced to engage in sex acts against your will?
☐	☐	Been a victim of human trafficking?
☐	☐	Ever been incarcerated?
☐	☐	Do you have any "street" tattoos?

Male Symptom History

Yes	No	(check appropriate boxes)
☐	☐	Clear, milky or mucoid urethral discharge
☐	☐	Dysuria , urethral "itch", frequency, urgency
☐	☐	Sore throat and/or hoarseness
☐	☐	Scrotal pain, swelling, redness
☐	☐	Rectal discharge, pain during defecation
☐	☐	Rash
☐	☐	Asymmetric, painful, swollen joints

Female Symptom History

Yes	No	(check appropriate boxes)
☐	☐	Hx of abnormal Pap smear CONTACT PHYSCIAN
		Date of Pap smear: _____
☐	☐	Increased vaginal
☐	☐	Lower abdominal pain/discomfort, dyspareunia
☐	☐	Urinary symptoms - pain, frequency, urgency
☐	☐	Perihepatic pain
☐	☐	Abn. bleeding (vaginal, menses, post-coital)
☐	☐	Nausea and/or vomiting
☐	☐	Fever and/or chills
☐	☐	Sore throat and/or hoarseness
☐	☐	Rash
☐	☐	Asymmetric, painful, swollen joints
☐	☐	Rectal discharge, itching, soreness, bleeding, or painful bowel movements

Date of Last menstrual period:_____

☐ Regular ☐ Irregular

Frequency:_____

Are you pregnant? ☐ Yes ☐ No ☐ Unknown

Are you breastfeeding? ☐ Yes ☐ No

Contraception? ☐ Yes ☐ No

☐ Birth control pill ☐ Emerg. contraceptive pill

☐ Implant ☐ Tubal ligation

☐ Condoms ☐ Hysterectomy

☐ **IUD - CONTACT PHYSICIAN**

☐ Diaphragm Use correctly? ☐ Yes ☐ No

☐ Injectable, Last given:

Previous STD

☐ Chlamydia ☐ Gonorrhea

☐ Hep. C ☐ Herpes

☐ HIV ☐ HPV

☐ PID____ ☐ Syphilis

☐ Other:

Comments:

Medications

Antibiotics last 4 weeks? ☐ Yes ☐ No

Name

Purpose

Chronic medications ☐ Yes ☐ No

Use reverse for addt'l. notes

Allergies

Allergic to any medications?

☐ Yes ☐ No ☐ Unknown

If Yes, list:

Other allergies?

☐ Yes ☐ No ☐ Unknown

If Yes, list:

Immunization HX

Hepatitis A (HAV) # doses: _____

☐ Yes ☐ No ☐ Unknown

Hepatitis B (HBV) # doses: _____

☐ Yes ☐ No ☐ Unknown

Human Papillomavirus (HPV) # doses: _____

☐ Yes ☐ No ☐ Unknown

Tdap date: _____

☐ Yes ☐ No ☐ Unknown

Signature of Interviewer	Title of Interviewer	Date
Signature of Provider (if not the interviewer)	Title of the Provider	Date
Signature of the Interpreter (if applicable)		Date:
DIS Signature		Date:
☐ Pt. Declined Services (Specify)	Signature for Declination:	Date:

Physical Examination

Scalp, brow, lashes ☐ Abn:
☐ No nits; no hair loss

Oropharynx: ☐ Abn:
☐ No lesions; No erythema; No tonsillar exudate

Cervical/supraclavicular/axillary/epitrochlear nodes ☐ Abn:
☐ No adenopathy

Face/arms/chest/back ☐ Abn:
☐ Clear; no lesions; no rashes

Hands/feet (palmer/plantar) ☐ Abn:
☐ No lesions; no erythema, no rash

Abdomen ☐ Abn:
☐ No tenderness or rebound tenderness reported

Inguinal nodes ☐ Abn:
☐ No adenopathy

Pubic area ☐ Abn:
☐ No lesions; no rashes; no lice/nits

Penis Circumcised: ☐ Yes ☐ No ☐ Abn:
☐ No lesions ☐ No discharge ☐ No erythema

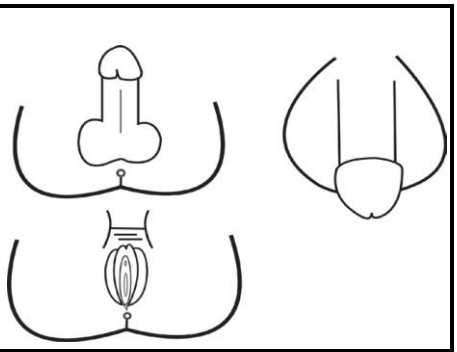
Scrotum ☐ Abn:
☐ No tenderness; no nodules, no lesions

Vulva/vaginal ☐ Abn:
☐ No lesions; no rashes; no erythema ☐ no discharge

Anus ☐ Abn:
☐ No lesions; no erythema ☐ no discharge

Additional Findings:

Additional Notes:



Description of Discharge (if present)

Female Clients	Male Clients
Amount	Amount
☐ Small	☐ Small
☐ Moderate	☐ Moderate
☐ Large	☐ Large
Color (check all that apply)	Color (check all that apply)
☐ Clear	☐ Clear
☐ White	☐ White
☐ Yellow	☐ Yellow
☐ Green	☐ Green
☐ Purulent	☐ Purulent
☐ Gray/off white	☐ Other, specify:
☐ Bloody	
☐ Other, specify:	

Clinical Impression

☐ No disease, pending laboratory results
☐ Chlamydia (200)
☐ Gonorrhea (300)
☐ Syphilis (700)
- ☐ Early Syphilis, < 1 yr.
- ☐ Late Syphilis, > 1 yr.
- ☐ Primary Syphilis
- ☐ Secondary Syphilis

☐ Other:
☐ Referred to:

For HIV/STD DIS Use Only

☐ Serofast/decreasing RPR titer (705)
☐ Primary syphilis (710)
☐ Secondary syphilis (720)
☐ Early latent syphilis, < 1 yr. (730)
☐ Latent syphilis, duration unknown(740)
☐ Late latent syphilis > 1 yr. (745)

Treatment

☐ No treatment indicated ☐ No tx, referred for additional linical/lab eval.
☐ Treatment indicated Comments:
- ☐ Reviewed client's allergy Hx
- ☐ Reviewed client's pregancy status
- ☐ Reviewed client's breastfeeding status

Treatment:

- ☐ Amoxicillin 500 mg PO TID x 7 days
- ☐ Azithromycin 1 gm PO stat x 1
- ☐ Azithromycin 2 gm PO stat x 1
- ☐ Benzathine penicillin G 1.2 MU IM x2 Site 1:_____Time1: _____; Site2:_____ Time2:_____
- ☐ Benzathine penicillin G 2.4 MU IM Dose1 Site1:_____Time1: _____;
  (if 3) Dose 2 site:_____Time2:_____; Dose 3 Site:_____ Time3:_____.
- ☐ Ceftriaxone 250 mg IM stat x 1 Site:_____Time: _____
- ☐ Gentamycin 240 mg IM Site:_____Time: _____
- ☐ Doxycycline 100 mg PO BID x
- ☐ Cefixime 400 mg PO Stat x 1

☐ Medication instructions provided according to policy

Signature/title of Person dispensing/administering medications | Date

Patient Education

☐ Avoid sexual contact for _____days
☐ Medication instructions/side effects given
☐ Abstain from alcohol for _____days
☐ Safer sex practices discussed (condom use, back-up contraceptive)
☐ Pregnancy counseling and referral
☐ Referral for well woman/PAP/Birth control
☐ Patient-delivered Partner Therapy ☐ Immunizations
☐ Skin care instructions ☐ Partner notification
☐ Patient handouts given ☐ Kick Count (Syphilis)
☐ Tobacco cessation referral ☐ Social media / phone apps
☐ Alcohol/substance abuse referral ☐ Other:

Vaccination(s) Needed

☐ Hep A 1 2	☐ Hep B 1 2 3	☐ Hep A/B 1 2 3	☐ HPV4 1 2 3	☐ PCV13
☐ MMR 1 2	☐ Varicella 1 2	☐ Zoster	☐ Influenza	☐ MCV4	☐ Tdap

Return appointment: ☐ Yes ☐ No (if yes) Date of next apt: _____
Vaccinations given: ☐ Yes ☐ No (If yes see immunization card)

Ordered Laboratory Tests

☐ TPPA
☐ RPRC confirmatory ☐ RPR titer
☐ HIV with reflex confirmatory testing
☐ Chlamydia/Gonorrhea NAAT (urine)
☐ Pregnancy Test: ☐ Positive ☐ Negative
☐ Other:

Follow-up for Laboratory Test Results

☐ Lab results available date:_____
☐ Clinic will call with abn. results only or retest
☐ Clinic will call with all results
☐ Client will call for results
☐ Unique password to obtain results by phone
_____
☐ Preferred phone to contact client
_____
☐ Clinic may leave message at preferred #
☐ Other:

Disposition/Referral

☐ DIS referral ☐ Return Appt. Date/Time:_____
☐ Contact Cards ☐ Other:
☐ Referral:

DIS Activity

☐ Interviewed patient
☐ STD/HIV PC/PE counseling
☐ Record Search

adhere pt. ID sticker here

Cl. Name: _____
SS# _____
ID# _____
DOB: _____