

# STD History and Physical Assessment

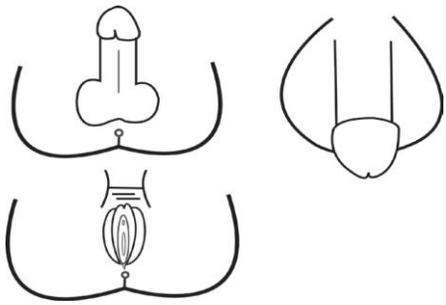
Date of Service: \_\_\_\_\_

Patient Demographics							
Last Name		First Name		Middle Initial	Pref. name/ AKA/ pronoun		Date of Birth
Sex (at birth)	Gender (all that apply)		Race	Ethnicity			
<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Female <input type="checkbox"/> Male	<input type="checkbox"/> Transgender <input type="checkbox"/> Self Define:	Pref. Pronoun:	<input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Hawaiian/Pacific Islander	<input type="checkbox"/> Asian <input type="checkbox"/> White	<input type="checkbox"/> African American <input type="checkbox"/> Other	<input type="checkbox"/> Hispanic <input type="checkbox"/> Non-Hispanic
Street Address			City	State	Zip	County	
Home Telephone		Cell Phone		<b>Vitals:</b>	Temp:	Pulse:	RR: BP:

**Referral Source:** \_\_\_\_\_

Reason for Visit	Male Symptom History	Previous STD
<p>Yes No Reason</p> <p><input type="checkbox"/> <input type="checkbox"/> Patient has genital lesions, genital discharge, or other symptoms suggestive of a sexually transmitted disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Patient has partner with genital lesions, genital discharge, or other symptoms suggestive of a sexually transmitted disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Patient has partner treated for a sexually transmitted disease</p> <p><input type="checkbox"/> <input type="checkbox"/> Patient referred by local or state DIS. Review labs and refer to appropriate STD treatment SDO</p> <p><input type="checkbox"/> <input type="checkbox"/> Patient requesting STD testing – denies reasons listed above</p> <p>If patient seen within past 30 days:</p> <p>Patient has persistent symptoms? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If Yes, was partner treated? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, treatment: _____</p> <p>(see contact sheet for partner names)</p> <p>Partner Sx/Sx Onset Date _____</p> <p>Partner Dx/Dx Date _____</p>	<p>Yes No (check appropriate boxes)</p> <p><input type="checkbox"/> <input type="checkbox"/> Clear, milky or mucoid urethral discharge</p> <p><input type="checkbox"/> <input type="checkbox"/> Dysuria , urethral “itch”, frequency, urgency</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat and/or hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> Scrotal pain, swelling, redness</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectal discharge, pain during defecation</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Asymmetric, painful, swollen joints</p>	<p><input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Hep. C <input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> HIV <input type="checkbox"/> HPV</p> <p><input type="checkbox"/> PID _____ <input type="checkbox"/> Syphilis</p> <p><input type="checkbox"/> Other: _____</p> <p>Comments: _____</p>
	Female Symptom History	Medications
	<p>Yes No (check appropriate boxes)</p> <p><input type="checkbox"/> <input type="checkbox"/> Hx of abnormal Pap smear CONTACT PHYSICIAN</p> <p>Date of Pap smear: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Increased vaginal</p> <p><input type="checkbox"/> <input type="checkbox"/> Lower abdominal pain/discomfort, dyspareunia</p> <p><input type="checkbox"/> <input type="checkbox"/> Urinary symptoms - pain, frequency, urgency</p> <p><input type="checkbox"/> <input type="checkbox"/> Perihepatic pain</p> <p><input type="checkbox"/> <input type="checkbox"/> Abn. bleeding (vaginal, menses, post-coital)</p> <p><input type="checkbox"/> <input type="checkbox"/> Nausea and/or vomiting</p> <p><input type="checkbox"/> <input type="checkbox"/> Fever and/or chills</p> <p><input type="checkbox"/> <input type="checkbox"/> Sore throat and/or hoarseness</p> <p><input type="checkbox"/> <input type="checkbox"/> Rash</p> <p><input type="checkbox"/> <input type="checkbox"/> Asymmetric, painful, swollen joints</p> <p><input type="checkbox"/> <input type="checkbox"/> Rectal discharge, itching, soreness, bleeding, or painful bowel movements</p> <p><b>Date of Last menstrual period:</b> _____</p> <p><input type="checkbox"/> Regular <input type="checkbox"/> Irregular</p> <p>Frequency: _____</p> <p><b>Are you pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p><b>Are you breastfeeding?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><b>Contraception?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Birth control pill <input type="checkbox"/> Emerg. contraceptive pill</p> <p><input type="checkbox"/> Implant <input type="checkbox"/> Tubal ligation</p> <p><input type="checkbox"/> Condoms <input type="checkbox"/> Hysterectomy</p> <p><input type="checkbox"/> <b>IUD - CONTACT PHYSICIAN</b></p> <p><input type="checkbox"/> Diaphragm Use correctly? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p><input type="checkbox"/> Injectable, Last given: _____</p>	<p><b>Antibiotics last 4 weeks?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Name _____</p> <p>Purpose _____</p> <p><b>Chronic medications</b> <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Use reverse for add'l. notes</p>
		Allergies
		<p><b>Allergic to any medications?</b></p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, list: _____</p>
		Other allergies?
		<p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>If Yes, list: _____</p>
		Immunization HX
		<p>Hepatitis A (HAV) # doses: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Hepatitis B (HBV) # doses: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Human Papillomavirus (HPV) # doses: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p> <p>Tdap date: _____</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown</p>

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: _____
<input type="checkbox"/> Pt. Declined Services (Specify) _____	Signature for Declination: _____	Date: _____

Physical Examination	Additional Notes:																															
<b>Scalp, brow, lashes</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No nits; no hair loss																																
<b>Oropharynx:</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No lesions; No erythema; No tonsillar exudate																																
<b>Cervical/supraclavicular/axillary/epitrochlear nodes</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No adenopathy																																
<b>Face/arms/chest/back</b> <input type="checkbox"/> Abn: <input type="checkbox"/> Clear; no lesions; no rashes																																
<b>Hands/feet (palmer/plantar)</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No lesions; no erythema, no rash																																
<b>Abdomen</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No tenderness or rebound tenderness reported																																
<b>Inguinal nodes</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No adenopathy																																
<b>Pubic area</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No lesions; no rashes; no lice/nits																																
<b>Penis</b> Circumcised: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Abn: <input type="checkbox"/> No lesions <input type="checkbox"/> No discharge <input type="checkbox"/> No erythema																																
<b>Scrotum</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No tenderness; no nodules, no lesions																																
<b>Vulva/vaginal</b> <input type="checkbox"/> Abn: <input type="checkbox"/> No lesions; no rashes; no erythema <input type="checkbox"/> no discharge		<table border="1" style="width:100%; border-collapse: collapse;"> <thead> <tr> <th colspan="2">Description of Discharge (if present)</th> </tr> <tr> <th style="width:50%;">Female Clients</th> <th style="width:50%;">Male Clients</th> </tr> </thead> <tbody> <tr> <td>Amount</td> <td>Amount</td> </tr> <tr> <td><input type="checkbox"/> Small</td> <td><input type="checkbox"/> Small</td> </tr> <tr> <td><input type="checkbox"/> Moderate</td> <td><input type="checkbox"/> Moderate</td> </tr> <tr> <td><input type="checkbox"/> Large</td> <td><input type="checkbox"/> Large</td> </tr> <tr> <td>Color (check all that apply)</td> <td>Color (check all that apply)</td> </tr> <tr> <td><input type="checkbox"/> Clear</td> <td><input type="checkbox"/> Clear</td> </tr> <tr> <td><input type="checkbox"/> White</td> <td><input type="checkbox"/> White</td> </tr> <tr> <td><input type="checkbox"/> Yellow</td> <td><input type="checkbox"/> Yellow</td> </tr> <tr> <td><input type="checkbox"/> Green</td> <td><input type="checkbox"/> Green</td> </tr> <tr> <td><input type="checkbox"/> Purulent</td> <td><input type="checkbox"/> Purulent</td> </tr> <tr> <td><input type="checkbox"/> Gray/off white</td> <td><input type="checkbox"/> Other, specify:</td> </tr> <tr> <td><input type="checkbox"/> Bloody</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Other, specify:</td> <td></td> </tr> </tbody> </table>	Description of Discharge (if present)		Female Clients	Male Clients	Amount	Amount	<input type="checkbox"/> Small	<input type="checkbox"/> Small	<input type="checkbox"/> Moderate	<input type="checkbox"/> Moderate	<input type="checkbox"/> Large	<input type="checkbox"/> Large	Color (check all that apply)	Color (check all that apply)	<input type="checkbox"/> Clear	<input type="checkbox"/> Clear	<input type="checkbox"/> White	<input type="checkbox"/> White	<input type="checkbox"/> Yellow	<input type="checkbox"/> Yellow	<input type="checkbox"/> Green	<input type="checkbox"/> Green	<input type="checkbox"/> Purulent	<input type="checkbox"/> Purulent	<input type="checkbox"/> Gray/off white	<input type="checkbox"/> Other, specify:	<input type="checkbox"/> Bloody		<input type="checkbox"/> Other, specify:	
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<b>Additional Findings:</b>																																
<b>Clinical Impression</b> <input type="checkbox"/> No disease, pending laboratory results <input type="checkbox"/> Chlamydia (200) <input type="checkbox"/> Gonorrhea (300) <input type="checkbox"/> Syphilis (700) <input type="checkbox"/> Early Syphilis, < 1 yr. <input type="checkbox"/> Late Syphilis, > 1 yr. <input type="checkbox"/> Primary Syphilis <input type="checkbox"/> Secondary Syphilis <input type="checkbox"/> Other: <input type="checkbox"/> Referred to:	<b>Treatment</b> <input type="checkbox"/> No treatment indicated <input type="checkbox"/> No tx, referred for additional clinical/lab eval. <input type="checkbox"/> Treatment indicated <input type="checkbox"/> Reviewed client's allergy Hx <input type="checkbox"/> Reviewed client's pregnancy status <input type="checkbox"/> Reviewed client's breastfeeding status  <b>Treatment:</b> <input type="checkbox"/> Amoxicillin 500 mg PO TID x 7 days <input type="checkbox"/> Doxycycline 100 mg PO BID x <input type="checkbox"/> Azithromycin 1 gm PO stat x 1 <input type="checkbox"/> Cefixime 400 mg PO Stat x 1 <input type="checkbox"/> Azithromycin 2 gm PO stat x 1 <input type="checkbox"/> Benzathine penicillin G 1.2 MU IM x2 Site 1: _____ Time1: _____ ; Site2: _____ Time2: _____ <input type="checkbox"/> Benzathine penicillin G 2.4 MU IM Dose1 Site1: _____ Time1: _____ ; (if 3) Dose 2 site: _____ Time2: _____ ; Dose 3 Site: _____ Time3: _____ . <input type="checkbox"/> Ceftriaxone 250 mg IM stat x 1 Site: _____ Time: _____ <input type="checkbox"/> Gentamycin 240 mg IM Site: _____ Time: _____ <input type="checkbox"/> Medication instructions provided according to policy Signature/title of Person dispensing/administering medications: _____ Date: _____																															
<b>For HIV/STD DIS Use Only</b> <input type="checkbox"/> Serofast/decreasing RPR titer (705) <input type="checkbox"/> Primary syphilis (710) <input type="checkbox"/> Secondary syphilis (720) <input type="checkbox"/> Early latent syphilis, < 1 yr. (730) <input type="checkbox"/> Latent syphilis, duration unknown(740) <input type="checkbox"/> Late latent syphilis > 1 yr. (745)	<b>Vaccination(s) Needed</b> <input type="checkbox"/> Hep A 1 2 <input type="checkbox"/> Hep B 1 2 3 <input type="checkbox"/> Hep A/B 1 2 3 <input type="checkbox"/> HPV4 1 2 3 <input type="checkbox"/> PCV13 <input type="checkbox"/> MMR 1 2 <input type="checkbox"/> Varicella 1 2 <input type="checkbox"/> Zoster <input type="checkbox"/> Influenza <input type="checkbox"/> MCV4 <input type="checkbox"/> Tdap Return appointment: <input type="checkbox"/> Yes <input type="checkbox"/> No (if yes) Date of next apt: _____ Vaccinations given: <input type="checkbox"/> Yes <input type="checkbox"/> No (If yes see immunization card)																															
<b>Patient Education</b> <input type="checkbox"/> Avoid sexual contact for _____ days <input type="checkbox"/> Medication instructions/side effects given <input type="checkbox"/> Abstain from alcohol for _____ days <input type="checkbox"/> Safer sex practices discussed (condom use, back-up contraceptive) <input type="checkbox"/> Pregnancy counseling and referral <input type="checkbox"/> Referral for well woman/PAP/Birth control <input type="checkbox"/> Patient-delivered Partner Therapy <input type="checkbox"/> Immunizations <input type="checkbox"/> Skin care instructions <input type="checkbox"/> Partner notification <input type="checkbox"/> Patient handouts given <input type="checkbox"/> Kick Count (Syphilis) <input type="checkbox"/> Tobacco cessation referral <input type="checkbox"/> Social media / phone apps <input type="checkbox"/> Alcohol/substance abuse referral <input type="checkbox"/> Other:	<b>Ordered Laboratory Tests</b> <input type="checkbox"/> TPPA <input type="checkbox"/> RPR confirmatory <input type="checkbox"/> RPR titer <input type="checkbox"/> HIV with reflex confirmatory testing <input type="checkbox"/> Chlamydia/Gonorrhea NAAT (urine) <input type="checkbox"/> Pregnancy Test: <input type="checkbox"/> Positive <input type="checkbox"/> Negative <input type="checkbox"/> Other:	<b>Follow-up for Laboratory Test Results</b> <input type="checkbox"/> Lab results available date: _____ <input type="checkbox"/> Clinic will call with abn. results only or retest <input type="checkbox"/> Clinic will call with all results <input type="checkbox"/> Client will call for results <input type="checkbox"/> Unique password to obtain results by phone _____ <input type="checkbox"/> Preferred phone to contact client _____ <input type="checkbox"/> Clinic may leave message at preferred # <input type="checkbox"/> Other:																														
<b>Disposition/Referral</b> <input type="checkbox"/> DIS referral <input type="checkbox"/> Return Appt. Date/Time: _____ <input type="checkbox"/> Contact Cards <input type="checkbox"/> Other: <input type="checkbox"/> Referral:	<b>DIS Activity</b> <input type="checkbox"/> Interviewed patient <input type="checkbox"/> STD/HIV PC/PE counseling <input type="checkbox"/> Record Search																															

adhere pt. ID sticker here

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