

CONFIDENTIAL SEXUALLY TRANSMITTED INFECTION CASE RECORD

Complete this form for Chlamydia, Gonorrhea or Syphilis

Patient information Preferred Name: _____ Legal Name (Last, First, MI): _____ Address: _____ City: _____ State: _____ Zip: _____ County: _____ Phone: _____ Age: _____ Date of Birth: _____	Race (mark all that apply) <input type="checkbox"/> White <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Middle Eastern	Ethnicity <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-hispanic
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Gender Identity <input type="checkbox"/> Man/Male <input type="checkbox"/> Woman/Female <input type="checkbox"/> Transgender man (trans man, trans masculine, or trans female-to-male) <input type="checkbox"/> Transgender woman (trans woman, trans feminine, or trans male-to-female) <input type="checkbox"/> Gender non-conforming, gender queer, or non-binary person <input type="checkbox"/> Another gender identity (please specify) _____	Patient Diagnosis <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis O RPR/VDRL O TPPA O Stage _____
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Specimen Collection/Clinical Diagnosis Name of Lab Performing Test: _____ Date Lab Collected: _____ Date result rcvd: _____ Test Type: _____ Test Source (anatomical site): _____	Clinic Name: _____ Health Care Provider: _____ Provider's Phone: _____
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Patient Treatment Information			
Date:	Med: Doxycycline	Dose: 100mg BID	Duration: x7 days
Date:	Med:	Dose:	Duration:
Date:	Med:	Dose:	Duration:

Contact Interview
 Interviewer: _____ Date: _____ Interviewing Agency: _____

Sex Partners(If necessary, please include contact information of additional individuals on the back of this form)

Name, Address, Phone number	Gender	Date of last exposure	Test Date	Date of treatment or previous treatment
1.				
2.				
3.				
4.				
5.				

Patient Risk Assessment Information (Mark applicable answers and complete patient exposure information within past 12 months as required by CDC)			
<input type="checkbox"/> Pregnant _____Weeks <input type="checkbox"/> Pelvic Inflammatory Disease <small>(Please See CDC's STI Treatment Guidelines for appropriate treatment)</small> <input type="checkbox"/> Sex W/ Male <input type="checkbox"/> Sex W/ Female <input type="checkbox"/> Sex W/ Transgender <input type="checkbox"/> Sex W/ Anonymous Partners <input type="checkbox"/> Sex W/O Condom <input type="checkbox"/> Sex W/ Known IDU <input type="checkbox"/> Sex While Intoxicated/High	<input type="checkbox"/> Exchanged Drugs/Money For Sex <input type="checkbox"/> Females Sex W/ Known MSM <input type="checkbox"/> Been Incarcerated <input type="checkbox"/> Drug Use <input type="checkbox"/> IV Drug Use <input type="checkbox"/> Shared Needles <input type="checkbox"/> Patients HIV Status: __Pos (+) __Neg (-) __Unk <input type="checkbox"/> Meet Partners on The Internet Apps Used:	<input type="checkbox"/> Prior STI History <input type="checkbox"/> Patient Counseled For HIV <input type="checkbox"/> Patient Screened for: o Chlamydia o Gonorrhea o Syphilis	Reason for Exam: Symptomatic Asymptomatic Contact to STI Prenatal <input type="checkbox"/> Partners Referred to Agencies Offering Free/Reduced-Cost Testing?