

## CONFIDENTIAL SEXUALLY TRANSMITTED INFECTION CASE RECORD

Complete this form for Chlamydia, Gonorrhea or Syphilis

<b>Patient information</b> Preferred Name: _____ Legal Name (Last, First, MI): _____ Address: _____ City: _____ State: _____ Zip: _____ County: _____ Phone: _____ Age: _____ Date of Birth: _____		<b>Race (mark all that apply)</b> <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		<b>Ethnicity</b> <input type="checkbox"/> Hispanic <input type="checkbox"/> Non-hispanic	
<b>Gender Identity</b> <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) _____			<b>Patient Diagnosis</b> <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis ○ RPR/VDRL ○ TPPA ○ Stage _____		
<b>Specimen Collection/Clinical Diagnosis</b> Name of Lab Performing Test: _____ Date Lab Collected: _____ Date result recd: _____ Test Type: _____ Test Source (anatomical site): _____		Clinic Name: _____ Health Care Provider: _____ Provider's Phone: _____			
<b>Patient Treatment Information</b>					
Date: _____		Med: Azithromycin		Dose: 1 gm	
Date: _____		Med: _____		Duration: x1	
<b>Contact Interview</b>					
Interviewer: _____ Date: _____ Interviewing Agency: _____					
<b>Sex Partners</b> (If necessary, please include contact information of additional individuals on the back of this form)					
<b>Name, Address, Phone number</b>		<b>Gender</b>	<b>Date of last exposure</b>	<b>Test Date</b>	<b>Date of treatment or previous treatment</b>
1.					
2.					
3.					
<b>Patient Risk Assessment Information</b> (Mark applicable answers and complete patient exposure information within past 12 months as required by CDC)					
<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"/> Patient's HIV status: + / - / unk <input type="checkbox"/> Meet partners on the internet? Apps used: _____		<input type="checkbox"/> Prior STD history <input type="checkbox"/> Patient counseled for HIV <input type="checkbox"/> Patient screened for: ○ Gonorrhea ○ Syphilis <input type="checkbox"/> Partners referred to agencies offering free/reduced-cost testing	
<input type="checkbox"/> Reason for exam ○ Symptomatic ○ Asymptomatic ○ Contact to STD ○ Prenatal					