STI/VAGINITIS MEDICAL VISIT

This medical record is ***confidential*** and will not be released to anyone except as may be required by law.

Barron Co DHHS-PH Programs
335 E Monroe Ave Room 338
Barron WI 54812
715-537-5691 Fax: 715-537-6274

Name:_____
Client No._____
DATE:_____/_____/_____

Name _____ Date of Birth _____ Age _____
(Last) (First)
Please call me (preferred name) _____ Preferred gender: He____ She____ Other:_____
Reason for visit: _____ Phone # to contact you: _____
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ___ Yes ____ No If yes, Where: _____

Please check if you are allergic to:
□Penicillin □Iodine □Zithromax □Doxycycline □Sulfa □Metal □Rocephin
□Tetracycline □Latex □Local anesthetic □Amoxicillin □No Allergies □Other _____

List medications, vitamins, over the counter drugs, and/or herbs you take:_____

MENSTRUAL HISTORY

Day last period began:_____ Was it normal? □ yes □ no
Have you had sex since your period? □ yes □ no

CONTRACEPTIVE HISTORY

Are you using a method of birth control now? □ yes □ no If yes, what kind? _____
Do you use condoms? □ yes □ no □ sometimes
Does your sexual partner(s) agree with your decision to prevent pregnancy and use birth control at this time? ___ yes ___ no
Has anyone ever done anything to your birth control– i.e. thrown away your pills, patches, rings or taken his condom off before or during sex? ___ yes ___ no

SEXUAL HISTORY

Have you had more than one sexual partner in your lifetime? ___ yes ___ no
Check if you have: ___ vaginal sex ___ oral sex ___ anal sex ___ sex with men ___ sex with women ___sex with both
Check if your partner(s) have: ___ vaginal sex ___ oral sex ___ anal sex ___ sex with men ___ sex with women ___ sex with both
Have you had a new partner or more than one partner in the **last 90 days?** __ yes __ no __don't know
Has your partner(s) had a new sex partner or more than one partner in the **last 90 days?** __yes __no __don't know
Have you ever engaged in a sexual activity where you felt you couldn't say no? ___yes ___ no
Have you had symptoms or a diagnosis of an STI in the **last 90 days?** __yes __no __don't know
Has your partner(s) had symptoms or a diagnosis of an STI in the **last 90 days?** __yes __no __don't know
Have you or your partner(s) used IV drugs? __yes __no __don't know
Check if you *ever* had? ___ Chlamydia ___ Gonorrhea ___ HPV/warts ___ Herpes ___ Syphilis
Have you had Chlamydia in the **last 5 years?** □ yes □ no

REVIEW OF SYSTEMS

Gastrointestinal

□ yes □ no Abdominal Pain
□ yes □ no Constipation
□ yes □ no Diarrhea
□ yes □ no Back Pain
□ yes □ no Rectal pain/bleeding/ discharge

Urinary

□ yes □ no Pain/burning with urination
□ yes □ no Frequent urination
□ yes □ no Fever/chills
□ yes □ no Blood in urine
□ yes □ no Have you urinated in the past hour

Vulvo/vaginal

□ yes □ no Sores
□ yes □ no Bumps
□ yes □ no Vaginal itching
□ yes □ no Vulvar itching
□ yes □ no Vaginal odor
□ yes □ no Vulvar soreness
□ yes □ no Discharge
If yes, color:_____
□ yes □ no Pain with intercourse

Respiratory

□ yes □ no Frequent Sore Throat

Have you or your partner(s) traveled more than 50 miles from the clinic? □ yes □ no
Does anything make your symptoms better? □ yes □ no If yes, what?_____
Have you recently taken antibiotics? □ yes □ no
If yes, when? _____ If yes, for what? _____ If yes, what kind?_____

To the best of my knowledge the above information is complete and correct.

Patient Signature _____ Date _____/_____/_____

Staff notes:

_____

_____

Face to face:_____ Counseling time:_____

Staff Signature: _____ Date _____/_____/_____