MALE STI VISIT

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

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

Client 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: _____
Can we send mail to you? □yes □no
Can we identify ourselves as Barron County Public Health if we call you? □yes □no

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:_____

SEXUAL HISTORY

Are you currently sexually active? □yes □no
When was the last time you had sex? _____
Have you had more than one sexual partner in your lifetime? □yes □ no
Do you use condoms? □ yes □ no □ sometimes
Has anyone ever messed with your condom before or during sex? □yes □ no
Have you or your partner(s) used IV drugs? □ yes □ no □don't know
Have you had a new partner or more than one partner in the **last 90 days?** □ yes □ no □don't know
Has your sex partner(s) had a new 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 a sexually transmitted infection in the **last 90 days?** □yes □no □ don't know
Has your partner(s) had symptoms or a diagnosis of a sexually transmitted infection in the **last 90 days?** □yes □ no □ don't know
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
Check if you *ever* had? ___ Chlamydia ___ Gonorrhea ___ HPV/warts ___Herpes ___ Syphilis
Are you and your sexual partner(s) in agreement about pregnancy prevention and birth control? □yes □ no

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ____ Yes ____ No
How many children do you hope to have? _____
When would you plan your child/children? _____
What do you plan to do until you (and your partner) are ready to have a baby? _____
What can I do today to help you achieve your plan? _____

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 Difficulty with urination
□ yes □ no Have you urinated in the past hour

Penis/Testes/Scrotum
□ yes □ no Discharge from penis
□ yes □ no Pain in testes
□ yes □ no Pain in scrotum
□ yes □ no Bumps on penis/scrotum
□ yes □ no Sores on penis/scrotum
□ yes □ no Pain or bleeding with sex or ejaculation

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 _____/_____/_____

Updated 9/30/2015