Sexually Transmitted Diseases
Form 2808

N.C. Department of Health and Human Services
Division of Public Health

1. Last Name | First Name | Mi

2. Patient Number | H | **3.** Date of Birth (Month / Day / Year)

4. Race
☐ 1. White
☐ 2. Black/African American
☐ 3. American Indian/Alaskan Native
☐ 4. Asian
☐ 5. Native Hawaiian/Other Pacific Islander
☐ 6. Other _____
Ethnicity: Hispanic Origin? ☐ Yes ☐ No

5. Gender
☐ 1. Male
☐ 2. Female
☐ 3. Transgender

6. County of Residence ☐☐☐

7. Allergies:

DATE OF VISIT _____

8a. Reason(s) for Visit (check all that apply):
☐ STD Screen/Check
☐ Asymptomatic
☐ Symptomatic
☐ *Positive test for_____
☐ Referred by DIS or Health Care Provider or ED
☐ Contact to person treated for_____
☐ Exposed to partner with symptoms
☐ Other_____

8b. Contact(s) verified by
(Check at least one):
☐ Partner notification card for _____
☐ Referral Source_____
☐ NC EDSS event ID
☐ Verbalization of Partner/Contact
☐ Medical Record of Partner/Contact
_____
_____
_____

Present	Absent	Symptom	Symptom Parameters: Specify location, quality, severity, duration, frequency and associated symptoms, if applicable. Document what the client did to relieve the symptoms and the effectiveness of the action.
☐	☐	Itch	
☐	☐	Irritation	
☐	☐	Pain	
☐	☐	Discharge	
☐	☐	Dysuria	
☐	☐	Ulcer/Lesion	
☐	☐	Rash	

9a. Prior STD/STI & Date Dx
☐ Bacterial Vaginosis_____
☐ Chlamydia_____
☐ Genital Warts_____
☐ Gonorrhea_____
☐ HIV_____
Date Dx:_____
State/Country Dx:_____
☐ Herpes ☐ oral _____
☐ genital_____
☐ MPC_____
☐ NGU_____
☐ PID_____
☐ Syphilis_____
Date Dx:_____
State/Country Dx:_____
Titer:_____
☐ Trichomoniasis_____
☐ Yeast_____
☐ Other_____
☐ None_____

9b. Vaccines & Testing
Hep B Vaccine
☐ No ☐ Yes ☐ Unk
injections _____
Last injection date :_____
Twinrix Vaccine
☐ No ☐ Yes ☐ Unk
injections _____
Last injection date :_____
Tdap Vaccine
☐ No ☐ Yes ☐ Unk
Last injection date :_____
HPV Vaccine
☐ No ☐ Yes ☐ Unk
injections _____
Last injection date :_____
Prior HIV Test
☐ No ☐ Yes ☐ Unk
Last test date :_____
HBV Status
☐ Unk ☐ Acute ☐ Chronic
(Date Dx) _____
HCV Status
☐ Unk ☐ Acute ☐ Chronic
(Date Dx) _____

10. Sexual Risk Assessment

Sexual partners past 60 days:
male _____ # female _____

Sites of client's exposure (last 60 days):
☐ Mouth ☐ Penis ☐ Vagina ☐ Anus

Have you ever:

Yes/No
☐ ☐ Had sex with partner of the same sex
☐ ☐ Had sex with a bisexual male
☐ ☐ Had sex for drugs or money
☐ ☐ Had sex with intravenous drug user
☐ ☐ Had sex with HIV(+) partner
☐ ☐ Paid for sex
☐ ☐ Shared needles

Date of last sexual encounter:
_____

In last 2 weeks:
sexual encounters _____
with condom use _____

Do you currently use:
Alcohol ☐ No ☐ Yes
Frequency _____
Injectable drugs ☐ No ☐ Yes
Last injection _____
Non-injectable drugs ☐ No ☐ Yes
_____
_____

11. For Women

LMP: _____ /_____ /_____
☐ Regular ☐ Irregular
Frequency_____
Last Pap: _____ /_____ /_____
☐ Normal ☐ Abnormal
Douche: ☐ Yes ☐ No
Frequency_____
Last_____
Are you pregnant?
☐ Yes ☐ No ☐ Don't know
Are you breastfeeding:
☐ Yes ☐ No

Contraception:
☐ None
☐ Emergency Contraceptive Pill
☐ OCP
☐ Injectable
Last given _____
☐ Implant
☐ Diaphragm
☐ IUD
☐ Tubal ligation
☐ Condoms
☐ Hysterectomy
☐ Other

13. Comments:

12. Other Pertinent History (document additional information in comments)

Antibiotics: (last 2 weeks)
☐ None ☐ Yes

Other present medication(s):
☐ None ☐ Yes

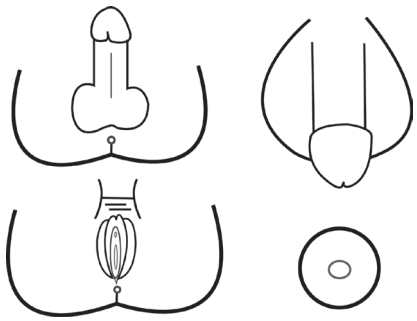
Reviewed client's self-history form when used by agency:
☐ Yes ☐ No ☐ N/A

☐ *If client is returning for treatment/counseling, re-interview the client for changes and if history remains the same, check this box.

Signature/Title of Interviewer:_____ **Signature/Interpreter:**_____ **Date:** _____

Signature/Title of Provider if not the Interviewer: _____ **Date:** _____

ATTACH PATIENT LABEL HERE



14. Physical Examination* Vital Signs, if clinically indicated: T:___ B/P: ___P____R____

☐ **Oropharynx**: no lesions; no erythema; no tonsillar exudate ☐ abnl:	☐ **Penis**: no lesions; no discharge ☐ abnl: Circumcised: ☐ yes ☐ no
☐ **Scalp, brows, lashes**: no nits; no hair loss ☐ abnl:	☐ **Scrotum**: no tenderness; no nodules ☐ abnl:
☐ **Cervical/supraclavicular/axillary/epitrochlear nodes**: no adenopathy ☐ abnl:	☐ **Vulva**: no lesions/rashes; no lice/nits ☐ abnl:
☐ **Skin**: clear; no lesions/rashes ☐ abnl:	☐ **Vagina**: no lesions; no erythema; no discharge ☐ abnl:
☐ **Abdomen**: no tenderness to palpation; no rebound tenderness ☐ abnl:	☐ **Cervix**: no lesions; no erythema; no discharge; no CMT ☐ abnl:
☐ **Inguinal nodes**: no adenopathy ☐ abnl:	☐ **Uterus**: no enlargement; no tenderness ☐ abnl:
☐ **Pubic area**: no lesions/rashes; no lice/nits ☐ abnl:	☐ **Anus**: no lesions ☐ abnl:
***Additional Findings:**	

Description of discharge (if present):

Female Clients		Male Clients
Amount: ☐ small ☐ moderate ☐ large	**Odor** (with or without KOH): ☐yes ☐no **pH:** ☐≥4.5 ☐<4.5	**Amount:** ☐ small ☐ moderate ☐ large
Adheres to vaginal wall: ☐yes ☐no		**Color** (check all that apply): ☐ clear ☐ yellow ☐ green ☐ purulent ☐ other, specify _____
Color (check all that apply): ☐ clear ☐ yellow ☐ gray/off white ☐ green ☐ bloody ☐ purulent ☐ color of discharge matches the white swab		

15. Laboratory

- ☐ Gonorrhea test: ☐ NAAT ☐ culture
  ☐ Cervical ☐ Urethral ☐ Urine
  ☐ Rectal ☐ Pharyngeal ☐ Vaginal
- ☐ Urethral gram stain:
  ☐ No GNID found ☐ ≥ 5 white cells, no GND
  ☐ GNID found ☐ Extracellular GND only
- ☐ Herpes test: ☐ culture ☐ serology
- ☐ HIV
- ☐ Chlamydia test: ☐ NAAT ☐ other
  ☐ Cervical ☐ Urethral ☐ Urine
  ☐ Rectal ☐ Pharyngeal ☐ Vaginal
- ☐ Syphilis serology
- ☐ Stat RPR: ☐ reactive ☐ non-reactive
- ☐ Darkfield: ☐ found ☐ not found
- ☐ Wet prep: ☐ clue cells ☐ yeast
  ☐ KOH+ ☐ trich ☐ WBCs _____
- ☐ Pap smear: ☐ HPV
- ☐ Pregnancy test: ☐ positive ☐ negative
- ☐ LE (leukoesterase): ☐ positive ☐ negative
- ☐ Other _____

16. Clinical Impressions/Diagnosis

- ☐ Bacterial vaginosis
- ☐ Candidal infection
- ☐ Cervicitis/MPC
- ☐ Chlamydia
- ☐ Epididymitis
- ☐ Gonorrhea
- ☐ Herpes - 1st episode or recurrent
- ☐ HIV
- ☐ HPV/Genital warts
- ☐ NGU
- ☐ Pediculosis pubis
- ☐ PID
- ☐ Scabies
- ☐ Syphilis: ☐ Unknown duration
  ☐ Primary ☐ Early latent
  ☐ Secondary ☐ Late latent
- ☐ Tinea cruris
- ☐ Trichomoniasis
- ☐ Contact to: _____
- ☐ Normal STD Screening, lab tests pending:
  _____
- ☐ Other: _____

17. Treatment/Therapy

- ☐ None
- ☐ Reviewed client's allergy history
- ☐ Reviewed client's pregnancy status
- ☐ Reviewed client's breastfeeding status
- ☐ Amoxicillin 500 mg PO TID x 7 days
- ☐ Azithromycin 1 gm PO stat x 1
- ☐ Azithromycin 2 gm PO stat x 1
- ☐ Benzathine penicillin G 2.4 MU IM
  ☐ bilateral gluteal muscles
  ☐ other site
- ☐ Ceftriaxone 250 mg IM stat x 1
- ☐ Doxycycline 100 mg PO BID x _____days
- ☐ Metronidazole 250 mg PO TID x 7 days
- ☐ Metronidazole 500 mg PO BID x 7 days
- ☐ Metronidazole 2 gm PO stat x 1
- ☐ Acyclovir/Valacyclovir/Famciclovir
  _____
- ☐ Cryotherapy
- ☐ TCA/Podophyllin/Client applied _____
- ☐ OTC pediculosis pubis treatment
- ☐ OTC fungal/yeast treatment
- ☐ Other _____

18. Instructions/Counseling

- ☐ Abstain from sex for ____ week(s) and until partner is treated
- ☐ Use condoms for risk reduction
- ☐ RTC if symptoms increase/persist
- ☐ RTC in _____(specify days, weeks or months)
- ☐ Partner notification discussed: ☐ Cards given
- ☐ Expedited partner therapy (EPT) # cards_____
- ☐ Control measures and counseling provided for HIV+
- ☐ Printed risk reduction/disease information given
- ☐ Client given a list of services provided/tests performed
- ☐ Referrals

19. Follow-up for Test Results:

- ☐ Clinic will call with results only if a test result is abnormal or requires re-testing
- ☐ Clinic will call with all test results
- ☐ Client will call for results
- ☐ Unique password to obtain test results by phone
  _____
- ☐ Preferred phone # to contact client:
  _____
- ☐ Clinic may leave message at preferred #
- ☐ Other

Date/Signature/Title of person administering/dispensing treatment if not the primary provider

- ☐ Medication instructions provided according to policy
- ☐ Restrictions for Alcohol Consumption given

Specify: _____

Notes:

Primary Provider Signature _____ Co-signature (if applicable) _____

☐ Enhanced Role RN ☐ CNM ☐ NP ☐ PA ☐ MD

Time Enhanced Role RN spent with patient: _____ min.=_____ units