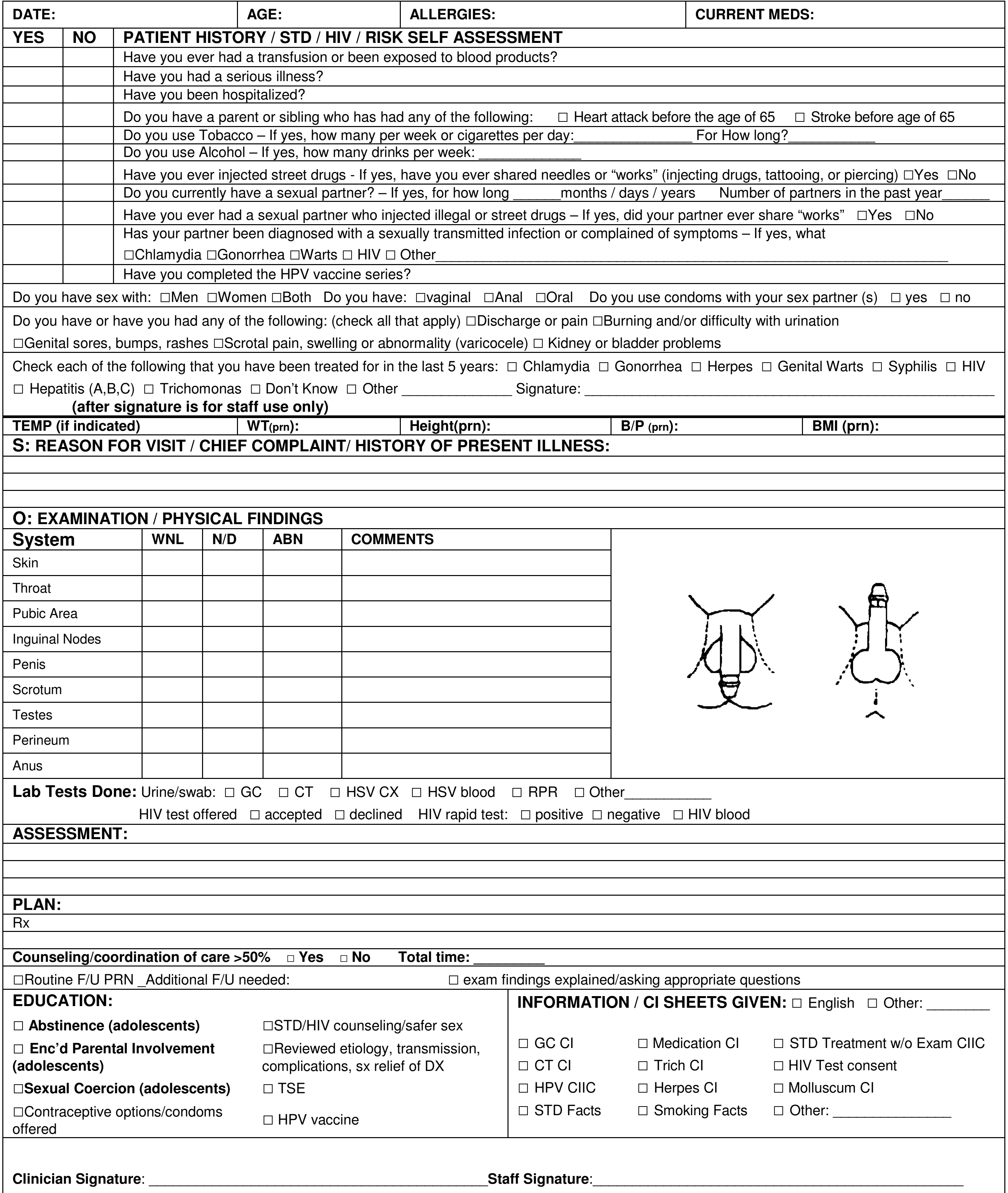
Planned Parenthood®
of Northeast Ohio



MALE INFECTION CHECK

DATE:	AGE:	ALLERGIES:	CURRENT MEDS:

YES	NO	PATIENT HISTORY / STD / HIV / RISK SELF ASSESSMENT
		Have you ever had a transfusion or been exposed to blood products?
		Have you had a serious illness?
		Have you been hospitalized?
		Do you have a parent or sibling who has had any of the following: ☐ Heart attack before the age of 65 ☐ Stroke before age of 65
		Do you use Tobacco – If yes, how many per week or cigarettes per day:_______________ For How long?___________
		Do you use Alcohol – If yes, how many drinks per week: _____________
		Have you ever injected street drugs - If yes, have you ever shared needles or "works" (injecting drugs, tattooing, or piercing) ☐Yes ☐No
		Do you currently have a sexual partner? – If yes, for how long ______months / days / years Number of partners in the past year______
		Have you ever had a sexual partner who injected illegal or street drugs – If yes, did your partner ever share "works" ☐Yes ☐No
		Has your partner been diagnosed with a sexually transmitted infection or complained of symptoms – If yes, what ☐Chlamydia ☐Gonorrhea ☐Warts ☐ HIV ☐ Other____
		Have you completed the HPV vaccine series?

Do you have sex with: ☐Men ☐Women ☐Both Do you have: ☐vaginal ☐Anal ☐Oral Do you use condoms with your sex partner (s) ☐ yes ☐ no

Do you have or have you had any of the following: (check all that apply) ☐Discharge or pain ☐Burning and/or difficulty with urination ☐Genital sores, bumps, rashes ☐Scrotal pain, swelling or abnormality (varicocele) ☐ Kidney or bladder problems

Check each of the following that you have been treated for in the last 5 years: ☐ Chlamydia ☐ Gonorrhea ☐ Herpes ☐ Genital Warts ☐ Syphilis ☐ HIV ☐ Hepatitis (A,B,C) ☐ Trichomonas ☐ Don't Know ☐ Other ______________ Signature: ____

(after signature is for staff use only)

TEMP (if indicated)	WT(prn):	Height(prn):	B/P (prn):	BMI (prn):

S: REASON FOR VISIT / CHIEF COMPLAINT/ HISTORY OF PRESENT ILLNESS:

O: EXAMINATION / PHYSICAL FINDINGS

System	WNL	N/D	ABN	COMMENTS
Skin				
Throat				
Pubic Area				
Inguinal Nodes				
Penis				
Scrotum				
Testes				
Perineum				
Anus				

Lab Tests Done: Urine/swab: ☐ GC ☐ CT ☐ HSV CX ☐ HSV blood ☐ RPR ☐ Other___________
HIV test offered ☐ accepted ☐ declined HIV rapid test: ☐ positive ☐ negative ☐ HIV blood

ASSESSMENT:

PLAN:
Rx

Counseling/coordination of care >50% ☐ Yes ☐ No Total time: _________

☐Routine F/U PRN _Additional F/U needed: ☐ exam findings explained/asking appropriate questions

EDUCATION:

- ☐ **Abstinence (adolescents)**
- ☐ **Enc'd Parental Involvement (adolescents)**
- ☐**Sexual Coercion (adolescents)**
- ☐Contraceptive options/condoms offered
- ☐STD/HIV counseling/safer sex
- ☐Reviewed etiology, transmission, complications, sx relief of DX
- ☐ TSE
- ☐ HPV vaccine

INFORMATION / CI SHEETS GIVEN: ☐ English ☐ Other: ________

☐ GC CI	☐ Medication CI	☐ STD Treatment w/o Exam CIIC
☐ CT CI	☐ Trich CI	☐ HIV Test consent
☐ HPV CIIC	☐ Herpes CI	☐ Molluscum CI
☐ STD Facts	☐ Smoking Facts	☐ Other: _______________

Clinician Signature: ____ **Staff Signature**:____

Place Patient Label Here