

STI HISTORY & PHYSICAL - FEMALE

Patient Name: _____ **Age:** _____ **Medical Record #:** _____ **Date:** _____

SUBJECTIVE:

CHIEF COMPLAINT / Why are you here today? Routine Screening Problem _____

- No** **Yes**
- Are you receiving medical care with another health provider? Reason for visit(s) _____
- Are you allergic to any medications, metals, foods, anesthesia or other products? List: _____
- Are you currently taking medications (including herbal remedies and vitamins)? List: _____

<p>FAMILY HISTORY Has your Grandmother (GM), Mother (M), or Sister (S) been diagnosed with any of the following?</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Breast cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Ovarian cancer</p> <p><input type="checkbox"/> <input type="checkbox"/> Uterine cancer</p> <p>PAST MEDICAL HISTORY – Have YOU been diagnosed or treated for any of the following:</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Kidney / Urinary Tract problems or infections</p> <p><input type="checkbox"/> <input type="checkbox"/> Genital problems / surgery</p> <p><input type="checkbox"/> <input type="checkbox"/> Pelvic infection / PID</p> <p><input type="checkbox"/> <input type="checkbox"/> Abnormal Pap smear</p> <p><input type="checkbox"/> <input type="checkbox"/> Serious illness or hospitalization</p> <p><input type="checkbox"/> <input type="checkbox"/> Vaccination for Hepatitis B</p> <p>REVIEW OF SYSTEMS</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Constitutional: Generally healthy</p> <p><input type="checkbox"/> <input type="checkbox"/> Oral: Ulcers / Sores in your mouth</p> <p><input type="checkbox"/> <input type="checkbox"/> Skin: Rash / Itching</p> <p>HEALTH HABITS / SOCIAL HISTORY</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Smokes: _____ cigarettes per day.</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol intake: _____ drinks per week.</p> <p><input type="checkbox"/> <input type="checkbox"/> Drugs use: daily / weekly / monthly. Type _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Alcohol and/or drugs cause problems in you life?</p> <p><input type="checkbox"/> <input type="checkbox"/> Others concerned with your alcohol/drug habits?</p> <p><input type="checkbox"/> <input type="checkbox"/> Afraid of your partner(s) / others?</p> <p><input type="checkbox"/> <input type="checkbox"/> Parent(s) or guardian is aware of your visit (Only answer if under age 18.)</p> <p>SEXUAL HISTORY Date you last had sex _____</p> <p># of sexual partners in last 30 days: _____</p> <p># of sexual partners in last 12 months: _____</p> <p># of partners in your lifetime: _____</p> <p>Partner(s): <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both</p> <p>Kind of sex: <input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Have you ever been forced to have sex?</p> <p><input type="checkbox"/> <input type="checkbox"/> Ever had a partner that had more than 1 partner?</p> <p><input type="checkbox"/> <input type="checkbox"/> Have any of you partners used IV drugs?</p>	<p align="center">INTERVIEWER COMMENTS</p>	<p>MENSTRUAL / CONTRACEPTIVE HISTORY When was the 1st day of your last period? _____</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Was your last period normal?</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you think you might be pregnant?</p> <p>Current method of birth control: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Do you consistently use condoms for safer sex?</p> <p>STI HISTORY – Have you ever had the following?</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Chlamydia Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Gonorrhea Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Herpes Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> HPV/warts Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Syphilis Date last treated: _____</p> <p><input type="checkbox"/> <input type="checkbox"/> Trichomonas Date last treated: _____</p> <p>STI TREATMENT</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Are you here for STI treatment?</p> <p><input type="checkbox"/> <input type="checkbox"/> Has your partner(s) been treated? Date of treatment _____ Name of her/his infection _____</p> <p>HISTORY OF CURRENT COMPLAINT</p> <p>No Yes</p> <p><input type="checkbox"/> <input type="checkbox"/> Genital sores, itching or pain.</p> <p><input type="checkbox"/> <input type="checkbox"/> Vaginal discharge.</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain / bleeding with sex.</p> <p><input type="checkbox"/> <input type="checkbox"/> Pain, burning, difficult or frequent urination.</p> <p><input type="checkbox"/> <input type="checkbox"/> A fever or any flu-like symptoms.</p> <p>Date symptoms first notice: _____</p> <p>I would like the following STI screening today:</p> <p><input type="checkbox"/> Chlamydia</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> HIV</p> <p><input type="checkbox"/> Syphilis</p> <p>I would like information on the following:</p> <p align="right">Given (Staff Initials)</p> <p><input type="checkbox"/> Chlamydia (N105) _____</p> <p><input type="checkbox"/> Gonorrhea (N103) _____</p> <p><input type="checkbox"/> HIV (N200) _____</p> <p><input type="checkbox"/> HPV / warts (N104) _____</p> <p><input type="checkbox"/> Syphilis _____</p> <p><input type="checkbox"/> Breast Self Exam _____</p>
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Patient Signature: _____

Date: _____

Interviewer Signature: _____

Date: _____

Patient Name: _____ Age: _____ Medical Record #: _____ Date: _____

Interviewer Notes:

- STI Risk Assessment done.
- Safer sex and condom use reviewed.
- ECP discussed / Fact Sheet NS0051 given.
- HIV pretest counseling done.
- Other _____.
- Pt. urged to discuss visit with parent or guardian.

Interviewer Signature: _____

Date: _____

OBJECTIVE:

Laboratory:

- | No | Yes | Pos | Neg |
|--------------------------|--------------------------|--------------------------|--------------------------|
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Wet Mount: No Yes Saline Results _____

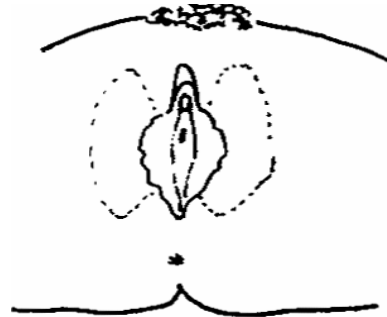
No Yes KOH Results _____

Urine Micro: No Yes Results _____

Medical Examination:

- Constitution:
BP _____ Temp _____
- Skin
- Lymph
- Abdomen
- Genitourinary

	Normal	Variant	Not done
Urethra	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vulva	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vagina	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cervix	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Adnexa R	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
L	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Gastrointestinal
Rectal inspection
- Psychological – Acute distress No Yes



ASSESSMENT:

Additional Fact Sheets Given:

- _____
- _____
- _____

PLAN:

No Yes Pt. OK for EHCs x 1 year.

Next visit due: _____

Clinician Signature: _____

Date: _____

