What brings you here today?

What symptoms are you experiencing today?

- Vaginal burning Yes No
- Vaginal pain Yes No
- Vaginal itch Yes No
- Vaginal Discharge Yes No
- Vaginal Odor Yes No
- Burning with urination Yes No
- Pain with urination Yes No
- Frequency with urination Yes No
- Strong urine odor Yes No
- Genital Lesions or Sores Yes No
- Genital rash or bumps Yes No
- Fever Yes No
- Other _____

When did these symptoms begin?

Have you ever HAD or been TREATED for:

- Gonorrhea Yes No
- Chlamydia Yes No
- Syphilis Yes No
- Herpes Yes No
- HIV Yes No
- Genital warts Yes No
- Trichomoniasis Yes No

Are your sexual partner(s) currently being treated for an STD? Yes No

If yes, what STD? _____ When?:_____

Date of last sexual contact: ____/____/____

How many sexual partners have you had in the last 2 months? _____ **Circle which: M F Both Other**

(label here)

Have you had unprotected sex with 2 or more partners in the last 6 months? Yes No If yes, how many? ____

Current medications: _____

_____

Allergies:_____

_____

Do you or your partner use birth control or STD protection? **YES NO**

If yes, please circle the method(s) you use:

Condoms	Depo-Provera
Hormonal implant	Cervical diaphragm
Hysterectomy	Tubal ligation
Sterilization	Oral Pill
IUD	Hormonal patch
Vaginal Ring	Spermicide (Foam/Gel)

- **First day of your last period:** _____/_____/_____
  - Was it normal? Yes No
- **Are you pregnant?** Unsure Yes No

- Have you ever had a Pap test Yes No
  - Was it normal? Yes No
- Do you use feminine hygiene products? Yes No

Do you have plans for pregnancy in the next 12 months? Yes, definitely Maybe Unsure No

Consent for examination and/or treatment:

I hereby consent to the performance of examination and treatment and to any laboratory tests and medical procedures which may be necessary or advisable in the opinion of the attending Family Planning Physician or attending Nurse Practitioner of the Riley County Health Department. The forenamed health department and attending physician and nurses have not guaranteed the success of the treatment or medication/device. All records of services rendered are considered confidential. No information regarding client's name or services obtained will be released without written consent of the client. The consent must specify type of records as well as the person/agency to which the information is to be released. I have been made aware that in the event of an emergency, I am to go to the nearest emergency room. The undersigned has read the above authorization and understands the same.

_____

Client Signature *Date*

_____

Provider Signature *Date*

FOR CLINIC USE ONLY:

Exam	N	AB	NA	
Urethra	___	___	___	_____
Vulva	___	___	___	_____
Vagina	___	___	___	_____
Cervix	___	___	___	_____
Cx Motion	___	___	___	_____
Adnexa	___	___	___	_____
Lymph Nodes	___	___	___	_____
Lesion	___	___	___	_____
Rash	___	___	___	_____
Other	___	___	___	_____

Acetic Acid Test: Positive___ Negative___ NA___

Discharge:

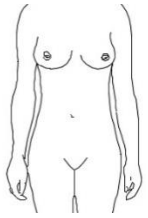
None	Scant	Small	Moderate	Profuse
Thin	Creamy	Curdy	Purulent	Gritty
Clear	White	Yellowish	Greenish	Bloody

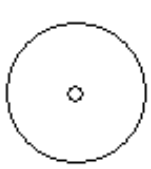
Positive Whiff Test

___Pamphlets given ___Interview completed
___Education/Counseling ___Consents signed
___Partner notification ____ Condoms provided
___Proper administration of meds
___Possible Disease side effects
___Possible Medication side effects

Plan: Call for test results on_____

Referral: PCP GYN FP Clinic OBGYN





LAB:	**Done**	**Deferred**
Chlamydia/Gonorrhea:		
Cervical Swab	_____	_____
Urine test	_____	_____
Wet Prep: Saline	_____	_____
Herpes Culture	_____	_____
VDRL	_____	_____
HIV	_____	_____
Hepatitis B Surface Antigen	_____	_____
Urine hCG	_____	_____
Urinalysis	_____	_____

Other:_____

(Wet Prep, hCG and UA results will be on lab sheet if done)

TREATMENT:

_____**Bactrim** DS 1 Tablet PO BID for **3** Days

_____**Bactrim** DS 1 Tablet PO BID for **7** Days

_____**Cipro** 250 mg 1 Tablet PO BID for 7 days

_____**Keflex** 250 mg 1 Tablet PO QID for 7 days

_____**Clindamycin** 300mg 1 cap PO BID x7 days

_____**Diflucan** 150 mg 1 Tab. PO today

_____**Rocephin** 250 mg IM times 1 dose

_____**Metronidazole** 500 mg 2 Tab. PO BID for 1 day

_____**Metronidazole** 500 mg 1 Tab. PO BID for **7** day

_____**Azithromycin** 1 gram PO times 1 dose

_____**Bicillin** 2.5 MU Intramuscular

_____**MetroGel** 0.75% 1 applicator intravaginally QHSx5days

PHYSICIAN SIGNATURE:_____

Nurses Notes: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

☐ Venipuncture site: _____ x_____ attempt(s)
By:_____

☐ Urine/ Swab collected per protocol.

☐ Counseled on safe sex practices and on use of barrier methods for STD/ HIV prevention

☐ Reproductive life plan discussed and BC counseling offered/ performed for client.

☐ STD Testing Summary Sheet Reviewed and provided to client with instructions to call back for results.

☐ Treatment was provided per standing orders as noted above.

Signature of Examiner: _____

Date:_____