What Brings You Here Today?

What Symptoms are you Experiencing Today?

- Urethral Burning Yes No
- Burning with Urination Yes No
- Urethral Pain Yes No
- Pain with Urination Yes No
- Frequency of Urination Yes No
- Urgent Urination Yes No
- Urethral Itch Yes No
- Urethral Discharge Yes No
- Odor Yes No
- Genital Lesions or Sores Yes No
- Genital Rash Yes No
- Bumps Yes No
- Other _____

When did these symptoms start?

Have You Ever Had or Been Treated For:

- Gonorrhea Yes No
- Chlamydia Yes No
- Syphilis Yes No
- Herpes Yes No
- HIV Yes No
- Warts Yes No
- Trichomoniasis Yes No

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

If so, what STD? _____

Last Sexual Contact Date: _____/_____/_____

How many Sexual Partners have you had in the past 2 months? _____Circle: M F Both

(label here)

Have you had unprotected sexual intercourse with 2 or more partners in the last 6 months Yes No

Medications_____

_____

Allergies: _____

_____

Are you allergic to any medication? Yes No

If yes, list:

Do you or your partner use contraception (Birth control) or STD prevention?

Yes No

If yes, circle the method(s) being used below:

Condoms	Depo-Provera
Hormonal Implant	Diaphragm/Cervical Cap
Hysterectomy	Tubal Ligation
Sterilization	Pill
IUD	Patch
Ring	Foam/Gel (Spermicide)

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***

Place Label Here

Exam	N	AB	NA	
Penis	___	___	___	_____
Testes	___	___	___	_____
Urethra	___	___	___	_____
Lymph Nodes	___	___	___	_____
Lesion	___	___	___	_____
Rash	___	___	___	_____
Other	___	___	___	_____

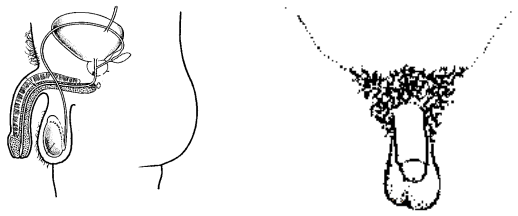
Acetic Acid Test:
Positive_____ Negative_____ NA_____

Discharge:

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

Positive Whiff Test

Summary of Variants



LAB:

	Done	Deferred
Chlamydia/Gonorrhea:		
Urethral Swab	_____	_____
Urine test	_____	_____
Herpes Culture	_____	_____
VDRL	_____	_____
HIV	_____	_____
Hepatitis B Surface Antigen	_____	_____
Urinalysis	_____	_____

Other:_____

(UA results will be on lab sheet if done)
Updated 7/2017

Riley County Health Department
2030 Tecumseh Road
Manhattan, KS 66502

TREATMENT:

____ TCA 85%

_____Rocephin 250mg. IM
_____Metronidazole – 2mg oral
_____Azithromycin 1gm stat
_____ Bicillin 2.5 MU Intramuscular, 1 dose
_____Other:_____

PHYSICIAN'S SIGNATURE:

___Pamphlets given ___Interview completed
___Education/Counseling ___Consents signed
pg.22 of FP Manual ___ Condoms Provided
___Partner notification
___Proper administration of meds
___Possible Disease side effects
___Possible Medication side effects

Plan: RTC in 10-14 days for test results_____
Referral: Primary Care Physician Dermatologist

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 on specified date for test results.
☐ Treatment was provided per standing orders as noted above. Post tx abstinence period discussed.

Signature of Examiner:_____