[_____]
Patient name

[_____]
ID Number

What is the main reason for your visit today?

Check symptoms you are having: ❑No complaint ❑discharge ❑odor ❑ sores
❑pain in genital area ❑rash ❑bumps ❑testicle pain ❑genital itch
❑burning/pain with urination ❑frequent urination ❑other:

When did your symptoms start?

Have you taken any medications or done anything to relieve the symptoms?

Are you allergic to any medicines or foods? ❑ yes ❑ no If you answered yes, please list what medicines or foods you are allergic to and your reaction to each:

Current medications (*Prescription / Over the counter)*: ❑ None ❑Multivitamins ❑ Folic Acid ❑Calcium
❑Birth Control (Type: _____) ❑ Other:

Have you had any hospitalizations, major injuries, or surgeries? ❑ yes ❑ no If you answered yes, please briefly explain:

List any Currently Diagnosed Medical Conditions:

Tobacco Use/ Smoke Exposure (cigarettes, cigars, pipe, dip, chew, snuff): ❑Never used ❑ Exposed to smoke
❑Past user: type _____ ❑Use now: type_____ (# per day _____)

Alcohol or Street Drugs: ❑None ❑Seldom: type_____ ❑Occasional: type_____
❑Frequent : type_____

Abuse / Neglect / Violence: ❑ No fear of harm ❑Pressure to have sex ❑Forced sexual contact
❑Fear of verbal/physical abuse ❑Daily needs not met ❑Sex for money or drugs

Sexually Active with: ❑ males ❑ females ❑ both males and females ❑ anonymous partners

Number of partners: in past month: _____ in past 2 months: _____ in past 12 months: _____

In the last 60 days,

have you had oral sex? ❑ no ❑ yes; when? _____ given / received/ both Partners: Male Female Both

have you had genital sex? ❑ no ❑ yes; when? _____ Partners: Male Female Both

have you had anal sex? ❑ no ❑ yes; when? _____ given / received/ both Partners: Male Female Both

Have you been treated for any STDs in your past? Check all that apply. ❑Chlamydia ❑Gonorrhea
❑Herpes ❑HIV/AIDS ❑HPV or Genital Warts ❑Syphilis ❑Trichomoniasis ❑other:

Date of last HIV test:

Do you use condoms? ❑ALWAYS ❑SOMETIMES ❑NEVER

FEMALES ONLY:

First day of last menstrual period: ____/____/____ # of pregnancies _____ # of live births _____

When was your last PAP? ____/____/____ Was the result normal? ❑ Yes ❑ No Explain:

Are you trying to get pregnant now? ❑Yes ❑No Have you douched in the last week? ❑Yes ❑No

Patient Signature: **Healthcare Provider Signature:** **Date:**

TO BE COMPLETED BY HEALTHCARE PROVIDER

PREVENTIVE HEALTH EDUCATION: *check counseling topics discussed today*

❑ STD	❑ Condom use for STD	❑ ATOD / Cessation	❑ Cancer	❑ Family planning
❑ HIV	❑ Condom use for Pregnancy prevention	❑ Mental Health	❑ SBE /Mammogram	❑ DV/SA/Abuse
❑ HIV Pretest		❑ Preconception / Folic Acid	❑ Pelvic / Pap	❑ Minor FP Patient Counseling – Sexual coercion. Abstinence. Benefits of parental involvement in choices.
❑ Partner Notification	❑ PPT - Options counseling		❑ STE / PSA	
❑ Risk Reduction				

Educational Handouts: ❑ STD ❑ HIV ❑ FPEM ❑ CSEM ❑ Other:

Patient verbalizes understanding of education given ❑

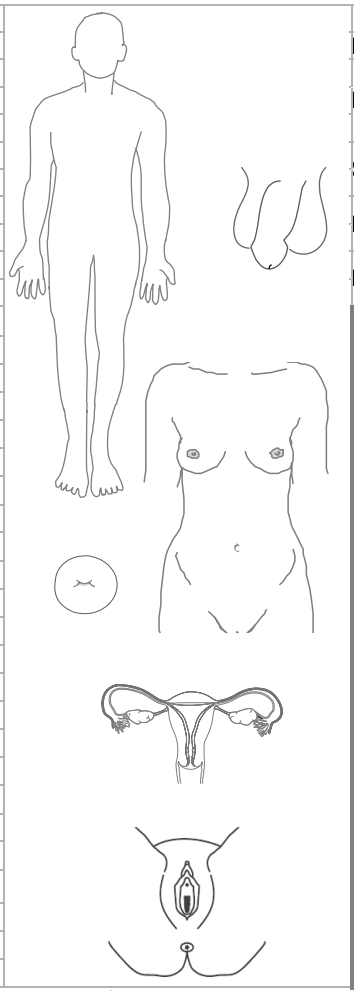
Patient Label

Is there a risk of exploitation? ❑ yes ❑ no

SUBJECTIVE / PRESENTING PROBLEM:

***OBJECTIVE:* General Multi-System Examination**

SYSTEM		NL	ABNORMAL
Constitutional	General appearance		
	Nutritional status		
	Vital signs		
HEENT	Head: Fontanels, Scalp		
	Eyes: PERRL		
	Conjunctivae, lids		
	Ear: Canals, Drums		
	Hearing		
	Nose: Mucosa/ Septum		
	Mouth: Lips, Palate		
	Teeth, Gums		
	Throat: Tonsils		
Neck	Overall appearance		
	Thyroid		
Respiratory	Respiratory effort		
	Lungs		
Cardiovascular	Heart		
	Femoral/Pedal pulses		
	Extremities		
Chest	Thorax		
	Nipples		
	Breasts		
Gastrointestinal	Abdomen		
	Liver / Spleen		
	Anus / Perineum		
Genitourinary	Male: Scrotum		
	Testes		
	Penis		
	Prostate		
	Female:Genitalia		
	Vagina		
	Cervix		
	Uterus		
	Adnexa		



SYSTEM		NL	ABNORMAL
Lymphatic	Neck, Axilla, Groin		
Musculoskeletal	Spine		
	ROM		
	Symmetry		
Skin / SQ Tissue	Inspection(rashes)		
	Palpation (nodules)		
Neurological	Reflexes		
	Sensation		
Psychiatric	Orientation		
	Mood / Affect		

EXPLANATION OF ABNORMAL FINDINGS:

ASSESSMENT:

PLAN:

Testing today:
❑ GC urine ❑ Chlamydia urine
❑ GC swab ❑ Chlamydia swab
❑ UA ❑ TST
❑ VDRL ❑ HIV Blood
❑ Pap ❑ HIV Oral
❑ Hgb ❑ Cholesterol
❑ Wet Mount ❑Herpes Culture
❑ Blood Glucose
❑ Urine PT / UCG: ❑Pos ❑Neg
Planned pregnancy? ❑ Yes ❑ No
❑Other:

Medications: ❑ N/A
❑ Condoms: # given _____
❑ Bicillin _____
❑ Metronidazole _____
❑ Rocephin _____
❑ Ceftriaxone _____
❑ Zithromax _____
❑ Doxycycline _____
❑ MV/ Folic Acid: # given ____
❑Other:_____
❑ Counseled on Benefits, SE and adverse reaction to medications given.

Recommendations made to client, for scheduling of follow-up testing and procedures, based on assessment: ❑ N/A
❑ Vision / Hearing ❑ FBS / GTT
❑ Speech ❑ Lipid Screen
❑ Dental ❑ Pap Smear
❑ Hgb ❑ Mammogram
❑ Sickle Cell ❑ Ultrasound
❑ Lead ❑ TST / CXR
❑ UCG / HCG ❑ Liver Panel
❑ Developmental Scr. Tests
❑ Other:

Referrals made: ❑ N/A
❑ PMD ❑ HANDS
❑ Pediatrician ❑ WIC
❑ Specialist: ❑ FP
❑ Radiology
❑ MNT with RD
❑ Medicaid
❑ Social Services
❑ 1-800-QUIT-NOW
❑ Cooper Clayton Classes
❑ Other:

Healthcare Provider Signature: **Date:** **Recommended RTC:**