STI Report Form

Clinic: _____
Address: _____
Phone: _____
Case #: _____

Patient Information

Name: _____ DOB: _____
Age: _____ Height: _____ Weight: _____
Race: _____ Sex: _____
Address: _____
Email: _____ Phone: _____

Medical History

Currently Pregnant? ☐ Yes ☐ No Estimated Due Date: _____
Date of Last Menstrual Cycle: _____ Length of Cycle: _____
Birth Control Method: _____
Marital Status:

Symptoms

☐ Cloudy/Bloody Discharge	☐ Strong Vaginal Odor	☐ Fever	☐ Sore Throat
☐ Yellow/Green Discharge	☐ Vaginal Itching/Irritation	☐ Aching Joints	☐ Headache
☐ Painful Urination	☐ Penile Itching/Irritation	☐ Weight Loss	☐ Rash
☐ Painful/Swollen Testicles	☐ Anal Itching	☐ Abdominal Pain	☐ Swollen Lymph Nodes
☐ Painful Bowel Movements	☐ Abnormal Menstruation	☐ Painful Sores	☐ Fatigue
☐ Painful Intercourse	☐ Testicular Pain	☐ Non-Painful Sores	☐ Diarrhea

Other Symptoms: _____
Symptom(s) Start Date: _____
Symptom Frequency: ☐ Constant ☐ Regular ☐ Intermittent ☐ Irregular
Specimen Source: ☐ Rectum ☐ Genitalia ☐ Urethra ☐ Cervix ☐ Throat ☐ Blood ☐ Lesion

Diagnosis

☐ Syphilis	☐ Chlamydia	☐ Gonorrhea	☐ Trichomoniasis
☐ HPV	☐ HIV	☐ Genital Herpes	☐ Pubic Lice
☐ Chancroid	☐ Scabies	☐ Hepatitis	☐ Other

Other: _____
Diagnosing Doctor: _____ Facility: _____
Date Reported: _____ Lab Confirmed? _____
Lab Name: _____ Collection Date: _____
Test Type: Test Results:

Treatment

Treatment Administered: _____ Date: _____ Dosage: _____
Medication Prescribed: _____ Frequency: _____ Dosage: _____
EPT Provided For Partner? _____ Date: _____ Dosage: _____
Treatment Prescribed by: _____ Phone: _____
Medication Prescribed by:

Notes

Physician Notes: