MALE STI VISIT

This medical record is confidential and will not be released to anyone except as may be required by law.

Polk County Reproductive Health
100 Polk County Plaza, Ste. 180
Balsam Lake, WI 54810
715-485-8575

Client Name:___________________
Client No.______________________
Date: ______/______/________

Name:____ Date of Birth _____/_____/________ Age ________
(Last) (First) (MI) mm / dd / yyyy
Please call me (preferred name) ____________________________ Preferred gender: He___ She___ Other: ________________
Reason for visit: __________________________ Phone # to contact you: _____________________________
Have you or your partner recently traveled to a region with known Zika or Ebola transmission? ___Yes ___No If yes, where:________ _________________
Can we send mail to you? ____Yes ____ No
Can we identify ourselves as ______________Health Clinic if we call you? ____Yes ____ No

Please check if you are allergic to:

❑ Penicillin ❑ Iodine ❑ Zithromax ❑ Doxycycline ❑ Sulfa ❑ Metal ❑ Rocephin
❑ Tetracycline ❑ Latex ❑ Local anesthetic ❑ Amoxicillin ❑ No allergies ❑ Other __________________

List medications, vitamins, over the counter drugs, and/or herbs you take:_____________________________________

SEXUAL HISTORY

Are you currently sexually active? ____Yes ____No
When was the last time you had sex? ________________________
Have you had more than one sexual partner in your lifetime? ____Yes ____No
Do you use condoms? ____Yes ____No ____sometimes
Has anyone ever messed with your condom before or during sex? ____Yes ____No
Have you or your partner(s) used IV drugs? ____Yes ____No ____Don't know
Have you had a new partner or more than one partner in the last 90 days? ____Yes ____No ____Don't know
Has your sex partner(s) had a new partner or more than one partner in the last 90 days?____Yes ____No ____Don't know
Have you ever engaged in a sexual activity where you felt you couldn't say no? ____Yes ____ No
Have you had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? ____Yes ____No ____Don't know
Has your partner(s) had symptoms or a diagnosis of a sexually transmitted infection in the last 90 days? ____Yes ____No ____Don't know
Check if you have: ___vaginal sex ___ oral sex ___anal sex ___ sex with men ___ sex with women ___ sex with both
Check if your partner(s) have: ___ vaginal sex ___ oral sex ___ anal sex ___ sex with men ___ sex with women ___sex with both
Check if you ever had? ___ Chlamydia ___ Gonorrhea ___ HPV/warts ___Herpes ___ Syphilis
Are you and your sexual partner(s) in agreement about pregnancy prevention and birth control? ____Yes ____No

REPRODUCTIVE LIFE PLAN

Do you hope to have any (more) children? ____Yes ____ No
How many children do you hope to have? ________________
When would you plan your child/children? ____
What do you plan to do until you (and your partner) are ready to have a baby? ______________________________________
What can I do today to help you achieve your plan? ____

REVIEW OF SYSTEMS

Gastrointestinal	Urinary	Penis/Testes/Scrotum
❑ Yes ❑ No Abdominal Pain	❑ Yes ❑ No Pain/burning with urination	❑ Yes ❑ No Discharge from penis
❑ Yes ❑ No Constipation	❑ Yes ❑ No Frequent urination	❑ Yes ❑ No Pain in testes
❑ Yes ❑ No Diarrhea	❑ Yes ❑ No Fever/chills	❑ Yes ❑ No Pain in scrotum
❑ Yes ❑ No Back Pain	❑ Yes ❑ No Blood in urine	❑ Yes ❑ No Bumps on penis/scrotum
❑ Yes ❑ No Rectal pain/bleeding/ discharge	❑ Yes ❑ No Difficulty with urination	❑ Yes ❑ No Sores on penis/scrotum
	❑ Yes ❑ No Have you urinated in the past hour	❑ Yes ❑ No Pain or bleeding with sex or ejaculation

Respiratory
❑ Yes ❑ No Frequent Sore Throat

Have you or your partner(s) traveled more than 50 miles from the clinic? ____Yes ____No
Does anything make your symptoms better? ____Yes ____No If yes, what?_____________________________________
Have you recently taken antibiotics? ____Yes ____No
If yes, when? _________________ If yes, for what? __________________ If yes, what kind?__________________

To the best of my knowledge the above information is complete and correct.
Patient Signature ______________________________________ Date ______/______/___________________________
Staff notes: ____

____

Face to face:________ Counseling time:_________________________
Staff Signature: ____ Date ______/______/__________________

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