



Y- Yes N-No R-Refused to Answer D-Did Not Ask

**Within the past 12 months has the patient:**

10. Been incarcerated?

11. Engaged in injection drug use?

12. Shared injection drug equipment?

Y/N/R/D

13. During the past 12 months, which of the following injection or non-injection drugs have been used? (Y/N/R/D)

None

Crack

Cocaine

Heroin

Methamphetamines

Nitrates/Poppers

Erectile dysfunction medications (e.g., Viagra)

Other, specify: \_\_\_\_\_

**Social History**

**Places Met Partners**

**Places Had Sex**

Type	Name
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Refused to answer

Type	Name
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Refused to answer

**Interview Period Partners**

Transgender

Partners Past Year

	Y	N	#	Unknown	Refused
Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Partners in 1x Period

Transgender

	Y	N	#	Unknown	Refused
Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

2

**Partner Internet Information**

Were any of the sex partners met through the internet within the last 12 months?  Yes  No  Refused to answer  Did not ask

**STD Testing**

Date Collected	Provider	Test	Specimen Source	Qualitative Result
___/___/___	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U
___/___/___	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U
___/___/___	_____	_____	<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U

**STD History**

Previous STD History? N Refused to Answer Y Unknown

**900 Partner Services Information-HIV Testing**

Refer for Test: \_\_\_\_\_ 900 Test: \_\_\_\_\_

Referral Date: \_\_\_\_\_ 900 Result: \_\_\_\_\_

**STD Treatment**

Treatment Date	Provider	Drug and Dosage
___/___/___	_____	Azithromycin 1 gm X 1
___/___/___	_____	Ceftriaxone 250mg X 1

Treatment Comments: \_\_\_\_\_ Provider Choice: \_\_\_\_\_

CORE INFO TAB ⇌

SYPHILIS ONLY

MANAGE ASSOCIATIONS ⇌

Add New Interview					
Date of Interview:					
Interview Type:      Initial/Original					
Interview Location:    Clinic    Field    Telephone					
Were contacts named at this interview:    N    Y					
Partner/Contact Information					
Partner	Contact Tab→	Name: Last	First	DOB or Age:	Gender: M F
	Contact Record Tab→	Jurisdiction:	Relationship w/patient? This patient Processing Decision: Field f/u	Named: PHN with date	Referral Basis: P1-Partner, Sex Last Exposure Date:
	Follow-up Investigation Tab→	Investigation Start Date:	Date Assigned to Investigation:	Notifiable:	
Supplemental Info Tab (optional)					
	Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:
Comments					
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