

OFFICIAL USE ONLY	
REFERRED BY:	
DATE OF VISIT:	
CLIENT ID:	

**COUNTY OF GLOUCESTER**  
 STATE OF NEW JERSEY  
 DEPARTMENT OF HEALTH & HUMAN SERVICES  
 204 EAST HOLLY AVENUE  
 SEWELL, NJ 08080  
 (856) 218-4101  
 (856) 218-4145 fax

<i>FREEHOLDER DIRECTOR</i> <b>ROBERT M. DAMMINGER</b>
<i>FREEHOLDER LIAISON</i> <b>JIM JEFFERSON</b>
<i>DIRECTOR</i> <b>TAMARISK JONES</b>

**S.T.D. MEDICAL RECORD**  
 (PLEASE PRINT CLEARLY)



LAST NAME: \_\_\_\_\_ FIRST NAME: \_\_\_\_\_ SEX: M F  
 BIRTHDATE: \_\_\_\_\_ AGE: \_\_\_\_\_ RACE: \_\_\_\_\_  
 ADDRESS: \_\_\_\_\_ TOWN: \_\_\_\_\_ ZIP: \_\_\_\_\_  
 HOME PHONE: ( ) \_\_\_\_\_ WORK/CELL PHONE: ( ) \_\_\_\_\_  
 SCHOOL: \_\_\_\_\_  
 STATUS: (PLEASE CIRCLE ONE) SINGLE MARRIED/LIVING TOGETHER SEPARATED DIVORCED WIDOWED  
 ALTERNATIVE ADDRESS/PHONE: \_\_\_\_\_  
 SEXUAL PARTNER'S NAME: \_\_\_\_\_ HENRIETTA CALLED: \_\_\_\_\_

**REASON FOR VISIT**

v	SYMPTOMS	ONSET/DURATION	DESCRIPTION
	DISCHARGE		
	PAIN WITH URINATION		
	GENITAL SORE		
	ORAL SORE		
	ITCHING		
	ABDOMINAL PAIN		
	RASH		
	FEVER		
	OTHER (BE SPECIFIC)		

HOW IS YOUR GENERAL STATE OF HEALTH? GOOD FAIR POOR (EXPLAIN IF POOR) \_\_\_\_\_  
 ARE YOU TAKING ANY MEDICATIONS NOW? NO YES LIST: \_\_\_\_\_  
 ARE YOU ALLERGIC TO ANY MEDICATIONS? NO YES LIST: \_\_\_\_\_  
 HAVE YOU EVER BEEN TREATED FOR A SEXUALLY TRANSMITTED DISEASE? NO YES  
 WHAT? \_\_\_\_\_ WHEN? \_\_\_\_\_  
 HAVE YOU EVER BEEN IMMUNIZED FOR HEPATITIS A OR B? YES NO WOULD YOU LIKE TO BE? YES NO

INSTRUCTIONS FOR STAFF: **CIRCLE ABNORMALITIES IN RED**

HOW OLD WERE YOU THE FIRST TIME YOU HAD SEX? \_\_\_\_\_  
 HOW MANY SEXUAL PARTNERS HAVE YOU HAD SINCE YOU BECAME SEXUALLY ACTIVE? \_\_\_\_\_  
 HOW MANY SEXUAL PARTNERS HAVE YOU HAD IN THE LAST THREE (3) MONTHS? \_\_\_\_\_  
 WHAT PARTS OF **YOUR** BODY DO YOU USE WHEN YOU HAVE SEX?  
 PENIS VAGINA MOUTH RECTUM OTHER \_\_\_\_\_  
 MY SEXUAL PARTNERS ARE: MALE FEMALE BOTH  
 MY REGULAR PARTNER IS: M/F NAME: \_\_\_\_\_ DATE OF LAST SEXUAL EXPOSURE? \_\_\_\_\_  
 MY CASUAL PARTNER IS: M/F NAME: \_\_\_\_\_ DATE OF LAST SEXUAL EXPOSURE? \_\_\_\_\_  
 IS YOUR PARTNER BEING SEEN TODAY? YES NO  
 DO YOU ROUTINELY USE CONDOMS? YES NO  
 WHAT STREET DRUGS DO YOU USE? \_\_\_\_\_ DO YOU WANT HELP TO STOP? YES NO

**WOMEN ONLY**

ARE YOU TRYING TO GET PREGNANT? YES NO  
 WHAT IS YOUR BIRTH CONTROL METHOD? PILL DIAPHRAGM IUD FOAMS & CONDOMS STERILIZED  
 WITHDRAWL NONE OTHER \_\_\_\_\_  
 HOW MANY TIMES HAVE YOU BEEN PREGNANT? \_\_\_\_\_  
 #CHILDREN \_\_\_\_\_ #ABORTIONS \_\_\_\_\_ #MISCARRIAGES \_\_\_\_\_  
 HOW OLD WERE YOU WHEN YOUR PERIODS STARTED? \_\_\_\_\_  
 ARE THEY REGULAR? YES NO DATE OF LAST PERIOD? \_\_\_\_\_  
 WAS IT NORMAL FOR YOU? YES NO WHAT WAS ABNORMAL? \_\_\_\_\_  
 DO YOU USE TAMPONS? NO YES AT NIGHT? YES NO HOW OFTEN DO YOU CHANGE THEM? \_\_\_\_\_  
 DO YOU DOUCHE? NO YES HOW OFTEN? \_\_\_\_\_ WITH WHAT? \_\_\_\_\_ LAST USE? \_\_\_\_\_  
 WHEN WAS YOUR LAST PAP SMEAR? \_\_\_\_\_ WAS IT NORMAL? YES NO  
 WERE YOU TOLD YOU NEEDED TREATMENT OR TO HAVE YOUR PAP REPEATED? YES NO

I, \_\_\_\_\_ GRANT PERMISSION TO THE GLOUCESTER COUNTY HEALTH DEPARTMENT TO OBTAIN SPECIMENS, PERFORM TESTS, ADMINISTER TREATMENTS, VACCINATIONS AND SHARE INFORMATION ABOUT ME THAT MAY BE NECESSARY TO PROVIDE PROPER MEDICAL CARE.

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

WITNESS SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

**COUNSELING**

HIV RISKS		REFERRED:	
CONDOMS		DISPENSED WITH INSTRUCTIONS	
DOUCHING			
TAMPONS			
CONTRACEPTION		REFERRED:	
DRUG USE		REFERRED:	
PRENATAL CARE		REFERRED:	
OTHER		REFERRED:	

COUNSELOR'S SIGNATURE: \_\_\_\_\_

## PHYSICAL ASSESSMENT

NO EXAM	NORMAL	EXAM	ABNORMAL FINDINGS
		H.E.E.N.T	
		OROPHARYNX	
		SKIN & HAIR	
		LYMPH NODES	
		BREASTS	
		ABDOMEN	
		EXTERNAL GENITALIA	
		URETHRA	
		ANO-RECTUM	
NO EXAM	NORMAL	FEMALE EXAM	ABNORMAL FINDINGS
		VULVA	
		VAGINA	
		CERVIX	
		UTERUS	
		ADENEXA	
		RECTO-VAGINAL	

## LABORATORY TESTING

TEST	DATE	RESULT	NEG	URINE	POS	NEG	WET PREP	POS	GONORRHEA/ CHLAMYDIA	
RPR				SUGAR			MYCELIA			
FTA				PROTEIN			AMINE		LOCATION	✓
UHCg				LEUKOCYTES			WBC'S>5		CERVIX	
				NITRITES			TRICH		URETHRA	
				PH			BUDS		URINE	
							CLUE			

**DIAGNOSIS:**

**TREATMENT ORDERED:**

**MEDICATION DISPENSED:**

### INSTRUCTIONS:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> SIDE EFFECTS     | <input type="checkbox"/> CONTRAINDICATIONS | <input type="checkbox"/> CONDOMS          |
| <input type="checkbox"/> CALL FOR RESULTS | <input type="checkbox"/> ABSTINENCE        | <input type="checkbox"/> PARTNER REFERRAL |
| <input type="checkbox"/> ADMINISTRATION   | <input type="checkbox"/> RESCREENING       | <input type="checkbox"/> REFERRAL _____   |

PRACTITIONER'S SIGNATURE: \_\_\_\_\_

