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

S.T.D. MEDICAL RECORD

(PLEASE PRINT CLEARLY)

Name: Last First Middle Initial	**Date of Birth**
Street Address	**Best Contact Phone Number(s)**
City State Zip	**Race/Ethnicity**
School Name (if applicable)	

Sex Assigned at Birth	**Gender Identity**	**Sexual Orientation**	**Marital Status**
☐ Male	☐ Male	☐ Straight	☐ Single
☐ Female	☐ Female	☐ Lesbian	☐ Married
☐ Intersex	☐ Transgender	☐ Gay	☐ Divorce
☐ Decline to answer	☐ Decline to answer	☐ Bisexual	☐ Widowed

Are you here with a sexual partner(s) yes or no If yes, name of partner(s) _____

REASON FOR VISIT

√	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 IMMUNIZED FOR HEPATITIS A OR B? YES NO WOULD YOU LIKE TO BE? YES NO

Have you EVER used IV drugs and/or had sex with someone who used/uses IV drugs?	**Have you taken any medications or street drugs in the past 30 days?**	**Sexual History** **# of partners in last 3 months:**	**Part(s) of YOUR BODY used to have sex?**
☐ Used IV drugs	☐ Yes	# Male	☐ Mouth/Oral
☐ Had sex with IV drug user	☐ No	#Female	☐ Vagina/Vaginal
☐ No	Medication/Drugs	**How old were you first time you had sex?** **How many sexual partners have you had since you became sexually active?**	☐ Anus/Rectal
☐ Don't know/decline to answer	Treatment for : Last Dose:	**When was last time being tested for an STD?** **Where?**	☐ Penis/Penile
Last time used IV drugs or had sex with IV drug user:		**When was the last time you had sex?**	☐ Other _____

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 YOU HAVE BEEN PREGNANT? _____

#CHILDREN_____ #ABORTIONS_____ #MISCARRIAGES_____

HOW OLD WERE YOU WHEN YOU ARE 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 EVER 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: _____

Risk Reduction Plan/Counseling

STD prevention			
Condom use		Dispensed w/instructions	
HIV Risks		REFERRED	
Drug Use		REFERRED:	
Contraception		REFERRED:	
PRENATAL CARE		REFERRED:	
PrEP Education		REFERRED:	
OTHER/Health Education		REFERRED:	

COUNSELOR'S SIGNATURE: _____

Nursing Notes:

_____
_____
_____
_____
_____

NURSE'S SIGNATURE: _____

CONTACT NOTIFICATION: _____ CLIENT WILL NOTIFY CONTACTS

_____ CLIENT REQUESTS ASSISTANCE

_____ CONTACT ANONYMOUS

CDRSS Entry: DATE_____ INITIALS_____

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 /TRICHOMONIAS***	
RPR					SUGAR				MYCELIA				
FTA					PROTEIN				AMINE			**LOCATION**	**√**
UHCG					LEUKOCYTES				WBC'S>5			ORAL	
					NITRITES				TRICH			RECTAL	
					PH				BUDS			URINE	
									CLUE				

DIAGNOSIS:
TREATMENT ORDERED:
MEDICATION DISPENSED:

INSTRUCTIONS:

- ☐ SIDE EFFECTS
- ☐ CALL FOR RESULTS
- ☐ ADMINISTRATION
- ☐ CONTRAINDICATIONS
- ☐ ABSTINENCE
- ☐ RESCREENING
- ☐ CONDOMS
- ☐ PARTNER REFERRAL
- ☐ REFERRAL_____

PRACTITIONER'S SIGNATURE: _____