Today’s Date:\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Initial STD Test: \_\_\_\_\_\_\_\_\_\_\_\_\_

**STD 3-Month Return Visit Health Questionnaire**

(Not for STD Results Visit)

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Name: |  | Pt ID #: |  | DOB: |  |  |
| Gender: | * Male
 | * Female
 | Females Only: LMP |  |  |

**STD Information**

|  |  |  |
| --- | --- | --- |
| **Variation: # Sexual Partners** | Past 90 Days |  |
| **Frequency: # Sexual Experiences** | Past 90 Days |  |

|  |  |
| --- | --- |
| **Any health changes since last visit?** |  |

**Do you have any of the following:**

|  |  |  |  |
| --- | --- | --- | --- |
| Sore throat? | Y / N | Frequent Urination? | Y / N |
| Genital pain? | Y / N | Pain/Burning with Urination? | Y / N |
| Abnormal discharge/odor? | Y / N | Blood in urine? | Y / N |
| **Since Your Last Visit:** |  |  |  |
| Have you had any sexual exposure to a person with a known STD? | Y / N | If yes, when and to what? | Date |  |

|  |  |
| --- | --- |
| **Do you use any of the following:** | **If Yes, please specify:** |
| OTC/Rx Medications? | Y / N |  |
| Drugs? | Y / N |  |
| Cigarettes? | Y / N |  |
| Alcohol? | Y / N |  |
|  |  |
| Are you allergic to latex? | Y / N |
| Do you have an allergy to any foods or medications? (If yes, please list medication and reaction) | Y / N |
| Any other health conditions/symptoms/concerns? |  |
| **Pregnancy Test Results** | * **Positive**
 | * **Negative**
 | * **N/A**
 |

*I have reviewed the above information with the patient,*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  |  |  |  |  |
| Nurse Signature |  | Title |  | Date |