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

Oneida Co. Health Department-
Reproductive Health Clinic
100 W. Keenan Street Rhinelander WI 54501
PH: 715-369-6116 Fax: 715-369-2553

(For OFFICE USE only)
Name:________________________
Client No.____________________
Date: / /

MALE STI VISIT

Name ____ Date of Birth _______________ Age _________
(Last) (First) (MI)
Reason for visit: ___________________________ Phone # to contact you: ___________________________
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
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 had symptoms or a diagnosis of an STI in the **last 90 days?** □yes □no □ don't know
Has your partner(s) had symptoms or a diagnosis of an STI in the **last 90 days?** □yes □ no □ don't know
Circle if you have: vaginal sex oral sex anal sex sex with men sex with women sex with both
Circle if your partner(s) have: vaginal sex oral sex anal sex sex with men sex with women sex with both
Circle if you *ever* had? Chlamydia Gonorrhea HPV/warts Herpes Syphilis

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	□ 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

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 Time:________ **Counseling time:**___________

Staff Signature: ____ **Date** ______/______/______

(Updated 12/05/2012)