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

STI/VAGINITIS MEDICAL VISIT

Name:_____
Client No._____
DATE:_____/_____/_____

Name: _____ Date of Birth _____ Age _____
(Last) (First) (MI) (mm/dd/yyyy)
Reason for visit: _____ Phone # to contact you: _____

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:_____

MENSTRUAL HISTORY

Day last period began:_____ Was it normal? □ yes □ no
Have you had sex since your period? □ yes □ no

CONTRACEPTIVE HISTORY

Are you using a method of birth control now? □ yes □ no If yes, what kind? _____
Do you use condoms? □ yes □ no □ sometimes

SEXUAL HISTORY

Have you had more than one sexual partner in your lifetime? □ yes □ no
When was the last time you had sex ?_____
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
Have you had a new partner or more than one partner in the **last 90 days?** ____ yes ____ no ____don't know
Has your partner(s) had a new sex 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
Have you or your partner(s) used IV drugs? __yes __no __don't know
Circle if you *ever* had? Chlamydia Gonorrhea HPV/warts Herpes Syphilis
Have you had Chlamydia in the **last 5 years?** □ yes □ no

REVIEW OF SYSTEMS

Gastrointestinal

□ yes □ no Abdominal Pain
□ yes □ no Constipation
□ yes □ no Diarrhea
□ yes □ no Back Pain
□ yes □ no Rectal pain/bleeding

Urinary

□ yes □ no Pain/burning with urination
□ yes □ no Frequent urination
□ yes □ no Fever/chills
□ yes □ no Blood in urine
□ yes □ no Have you urinated in the past hour

Vulvo / vaginal

□ yes □ no Sores
□ yes □ no Bumps
□ yes □ no Vaginal itching
□ yes □ no Vulvar itching
□ yes □ no Vaginal odor
□ yes □ no Vulvar soreness
□ yes □ no Discharge
If yes, color:_____
□ yes □ no Pain with intercourse

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 10/05/2012)