

**RESPECT CLINIC
ENCOUNTER FORM
FEMALE**

<attach patient label here>



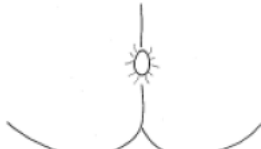
DATE: _____ Age: _____

REASON FOR VISIT	MEDICAL HISTORY	SYMPTOMS	
<input type="checkbox"/> Screening <input type="checkbox"/> Treatment <input type="checkbox"/> Symptoms <input type="checkbox"/> Test results <input type="checkbox"/> Partner has STD symptoms <input type="checkbox"/> Partner recently treated for STD <input type="checkbox"/> Other MARITAL STATUS <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Live-in partner RACE <input type="checkbox"/> White <input type="checkbox"/> Black/African American <input type="checkbox"/> American Indian/Alaska Native <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> Asian <input type="checkbox"/> Unknown/other ETHNICITY <input type="checkbox"/> Hispanic/Latino	YES NO <input type="checkbox"/> <input type="checkbox"/> Recent antibiotics <input type="checkbox"/> <input type="checkbox"/> Medications: <input type="checkbox"/> <input type="checkbox"/> Latex allergy/sensitivity <input type="checkbox"/> <input type="checkbox"/> Drug allergy/sensitivity: <input type="checkbox"/> <input type="checkbox"/> Chronic conditions: <input type="checkbox"/> <input type="checkbox"/> Contraception: <input type="checkbox"/> <input type="checkbox"/> Pregnant: ____ weeks LMP <input type="checkbox"/> Normal Last Pap <input type="checkbox"/> Normal <input type="checkbox"/> <input type="checkbox"/> HAV Immunization <input type="checkbox"/> <input type="checkbox"/> HBV Immunization	<input type="checkbox"/> None <input type="checkbox"/> Oral lesions/blisters/sores <input type="checkbox"/> Urethral discharge/pain <input type="checkbox"/> Dysuria <input type="checkbox"/> Urinary frequency <input type="checkbox"/> Urinary urgency <input type="checkbox"/> Abnormal vaginal discharge/odor <input type="checkbox"/> Genital rash/itching <input type="checkbox"/> Genital lesions/blisters/sores <input type="checkbox"/> Rectal lesions/sores <input type="checkbox"/> Rectal discharge/bleeding <input type="checkbox"/> Painful sex <input type="checkbox"/> Bleeding after sex <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Pelvic pain <input type="checkbox"/> Palmar/plantar rash <input type="checkbox"/> Other	Constitutional Symptoms <input type="checkbox"/> None <input type="checkbox"/> Headache <input type="checkbox"/> Fever/chills/night sweats <input type="checkbox"/> Fatigue <input type="checkbox"/> Body aches <input type="checkbox"/> Swollen glands <input type="checkbox"/> General body rash <input type="checkbox"/> Cough <input type="checkbox"/> Jaundice <input type="checkbox"/> Dark urine <input type="checkbox"/> Light colored stools <input type="checkbox"/> Weight loss: _____ lbs <input type="checkbox"/> Diarrhea <input type="checkbox"/> Oral thrush <input type="checkbox"/> Shingles <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Other

DISEASE	EXPOSED (DATE)	POS TEST (DATE)	DISEASE	EXPOSED (DATE)	POS TEST (DATE)	DISEASE	EXPOSED (DATE)	POS TEST (DATE)
<input type="checkbox"/> Gonorrhea	_____	_____	<input type="checkbox"/> Bacterial vaginosis	_____	_____	<input type="checkbox"/> HIV	_____	_____
<input type="checkbox"/> Chlamydia	_____	_____	<input type="checkbox"/> Trichomoniasis	_____	_____	<input type="checkbox"/> Hepatitis A	_____	_____
<input type="checkbox"/> Herpes simplex	_____	_____	<input type="checkbox"/> Candidiasis	_____	_____	<input type="checkbox"/> Hepatitis B	_____	_____
<input type="checkbox"/> Genital warts (HPV)	_____	_____	<input type="checkbox"/> Scabies	_____	_____	<input type="checkbox"/> Hepatitis C	_____	_____
<input type="checkbox"/> Syphilis	_____	_____	<input type="checkbox"/> Pubic lice	_____	_____	<input type="checkbox"/> Other	_____	_____

RISK ASSESSMENT			
Gender(s) of Partners <input type="checkbox"/> Male <input type="checkbox"/> Female Exposure Sites <input type="checkbox"/> Pharynx <input type="checkbox"/> Vagina <input type="checkbox"/> Anus/rectum	Condom Use <input type="checkbox"/> Always <input type="checkbox"/> Sometimes <input type="checkbox"/> Never Date Last Sexual Encounter: _____ <input type="checkbox"/> No condom last encounter	<input type="checkbox"/> Inconsistent condom/barrier use <input type="checkbox"/> Unsafe sex in past 3 months <input type="checkbox"/> New partner past 3 months <input type="checkbox"/> >1 partner past 3 months <input type="checkbox"/> Multiple lifetime partners <input type="checkbox"/> Partner has multiple partners <input type="checkbox"/> Previous STD(s) <input type="checkbox"/> Sex while intoxicated <input type="checkbox"/> Exchange sex for drugs/money <input type="checkbox"/> Forced to have sex	<input type="checkbox"/> In abusive relationship <input type="checkbox"/> Afraid of partner/others <input type="checkbox"/> Parenteral drug use <input type="checkbox"/> Share needles <input type="checkbox"/> Snort drugs <input type="checkbox"/> Received transfusion (before 1992) <input type="checkbox"/> Received blood products (before 1987) <input type="checkbox"/> Tattoo or body piercing past year <input type="checkbox"/> Partner is HIV infected <input type="checkbox"/> Health care worker/occupational risk

COMMENTS

PHYSICAL EXAM (Check findings; leave blank if not done)		<input type="checkbox"/> No exam done	<input type="checkbox"/> Genital exam only	
Oro-Pharynx <input type="checkbox"/> WNL <input type="checkbox"/> Ulcer <input type="checkbox"/> Exudate <input type="checkbox"/> Inflamed <input type="checkbox"/> Other Skin <input type="checkbox"/> WNL <input type="checkbox"/> Rash <input type="checkbox"/> Other Pubic Hair <input type="checkbox"/> WNL <input type="checkbox"/> Nits <input type="checkbox"/> Other	Lymph Nodes <input type="checkbox"/> WNL <input type="checkbox"/> Cervical <input type="checkbox"/> Axillary <input type="checkbox"/> Ing/fem <input type="checkbox"/> Enlarged <input type="checkbox"/> Tender <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other Abdomen <input type="checkbox"/> WNL <input type="checkbox"/> Tenderness <input type="checkbox"/> Mass <input type="checkbox"/> CVAT <input type="checkbox"/> Other	Vulva/Vagina <input type="checkbox"/> WNL <input type="checkbox"/> Erythema <input type="checkbox"/> Discharge: <input type="checkbox"/> Sm <input type="checkbox"/> Mod <input type="checkbox"/> Lg <input type="checkbox"/> Clear <input type="checkbox"/> Purulent <input type="checkbox"/> Ulcer <input type="checkbox"/> Vesicle <input type="checkbox"/> Warts <input type="checkbox"/> Rash <input type="checkbox"/> Menses <input type="checkbox"/> Other	Cervix <input type="checkbox"/> WNL <input type="checkbox"/> Ectopy <input type="checkbox"/> Friable/bleeding <input type="checkbox"/> Discharge: <input type="checkbox"/> Sm <input type="checkbox"/> Mod <input type="checkbox"/> Lg <input type="checkbox"/> Clear <input type="checkbox"/> Purulent <input type="checkbox"/> Ulcer <input type="checkbox"/> Vesicle <input type="checkbox"/> Other	Bimanual <input type="checkbox"/> WNL <input type="checkbox"/> CMT <input type="checkbox"/> Adnexal tenderness <input type="checkbox"/> Adnexal fullness/mass <input type="checkbox"/> Left <input type="checkbox"/> Right <input type="checkbox"/> Other Rectum <input type="checkbox"/> WNL <input type="checkbox"/> Warts <input type="checkbox"/> Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Other
COMMENTS				

STAT LAB RESULTS	LAB ORDERED/SENT OUT (Complete RESPECT Clinic Lab Test Order Form)																																
<table style="width:100%;"> <tr> <th style="width: 50%;">Done Test</th> <th style="width: 10%;">Pos</th> <th style="width: 10%;">Neg</th> </tr> <tr> <td><input type="checkbox"/> Wet Prep*</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Urinalysis Dipstick**</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Pregnancy test urine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Other (list)</td> <td></td> <td></td> </tr> </table>	Done Test	Pos	Neg	<input type="checkbox"/> Wet Prep*	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Urinalysis Dipstick**	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Pregnancy test urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Other (list)			<table style="width:100%;"> <tr> <th style="width: 50%;">Done Test (Circle source of specimen)</th> <th style="width: 10%;">Pos</th> <th style="width: 10%;">Neg</th> </tr> <tr> <td><input type="checkbox"/> Gonorrhea/Chlamydia DNA: Cervix Urethra Urine</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Gonorrhea Culture: Pharynx Rectum</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> Chlamydia Culture: Pharynx Rectum</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td><input type="checkbox"/> HSV Culture</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>			Done Test (Circle source of specimen)	Pos	Neg	<input type="checkbox"/> Gonorrhea/Chlamydia DNA: Cervix Urethra Urine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Gonorrhea Culture: Pharynx Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Chlamydia Culture: Pharynx Rectum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> HSV Culture	<input type="checkbox"/>	<input type="checkbox"/>
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*WET PREP: pH _____ Clue Cells ____ Trichomonas ____ Budding Yeast/Hyphae ____ Whiff Test ____
 **U/A DIP: Glu ____ Bil ____ Ket ____ Blo ____ pH (4.5-8.0) _____ SG (1.003-1.035) _____ Pro ____ Uro (0.1-1.0) _____ Nit ____ Leu ____

ASSESSMENT	TREATMENT*
<input type="checkbox"/> STD Screening (no symptoms) <input type="checkbox"/> Cervicitis <input type="checkbox"/> Vaginitis <input type="checkbox"/> Urethritis Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> Pelvic Inflammatory Disease <input type="checkbox"/> Herpes Simplex Virus, Initial <input type="checkbox"/> Herpes Simplex Virus, Recurrent <input type="checkbox"/> Human Papillomavirus <input type="checkbox"/> Bacterial Vaginosis <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Vulvovaginal Candidiasis <input type="checkbox"/> Tinea Cruris <input type="checkbox"/> Scabies <input type="checkbox"/> Pubic Lice <input type="checkbox"/> Syphilis: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> Early Latent Syphilis: Late Latent (>1 yr) <input type="checkbox"/> <input type="checkbox"/> 3 Syphilis (Late) <input type="checkbox"/> Neurosyphilis Human Immunodeficiency Virus <input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C Molluscum Contagiosum <input type="checkbox"/> Chancroid <input type="checkbox"/> <input type="checkbox"/> Other	Exposed to: <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Chlamydia <input type="checkbox"/> HIV/AIDS <input type="checkbox"/> Hepatitis <input type="checkbox"/> Herpes <input type="checkbox"/> Other <input type="checkbox"/> Proctitis <input type="checkbox"/> Pharyngitis <input type="checkbox"/> Other <input type="checkbox"/> Ceftriaxone 125 mg IM <input type="checkbox"/> Azithromycin 1 gm #1 <input type="checkbox"/> Doxycycline 100 mg BID X 7 <input type="checkbox"/> Erythromycin 500 mg QID X 7 <input type="checkbox"/> Ceftriaxone 250 mg IM + <input type="checkbox"/> Doxycycline 100 mg BID X 14 +/- Metronidazole 500 mg BID X 14 <input type="checkbox"/> Acyclovir 400 mg TID X 10 <input type="checkbox"/> Acyclovir 800 mg BID X 5 (within 1 day of outbreak) <input type="checkbox"/> Trichloroacetic acid <input type="checkbox"/> Podophyllin <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Metronidazole 500 mg BID X 7 Metronidazole: <input type="checkbox"/> 2 gm #1 <input type="checkbox"/> 500 mg BID X 7 Clotrimazole: <input type="checkbox"/> 100 mg/1% cr vag HS X 7 <input type="checkbox"/> 200 mg vag HS X 3 <input type="checkbox"/> Fluconazole 150 mg po #1 <input type="checkbox"/> Terbinafine BID X 14 <input type="checkbox"/> Ketoconazole BID X 14 <input type="checkbox"/> Permethrin 5% cream/1% lotion <input type="checkbox"/> Penicillin G 2.4 million units IM <input type="checkbox"/> Doxycycline 100 mg BID X 14 <input type="checkbox"/> Penicillin G 2.4 million units IM weekly X 3 <input type="checkbox"/> Doxycycline 100 mg BID X 28 See other resources for therapeutic guidelines See other resources for therapeutic guidelines See other resources for therapeutic guidelines <input type="checkbox"/> Cryotherapy <input type="checkbox"/> Azithromycin 1 gm #1 <input type="checkbox"/> Ciprofloxacin 500 mg BID X 3 <input type="checkbox"/> Ceftriaxone 250 mg IM

*The list does not include all treatment options for all patients; ceftriaxone, metronidazole, and azithromycin are available for dispensing

COUNSELING/PATIENT EDUCATION	FOLLOW-UP
<input type="checkbox"/> Advise partner notification <input type="checkbox"/> Condom/barrier use <input type="checkbox"/> Condoms given <input type="checkbox"/> Medication/avoid: <input type="checkbox"/> Sun <input type="checkbox"/> Alcohol <input type="checkbox"/> Abstinence during therapy (7 days) <input type="checkbox"/> Handouts: _____	<input type="checkbox"/> Contraception <input type="checkbox"/> Recommend Pap test/HCM <input type="checkbox"/> Advise HAV vaccine <input type="checkbox"/> Advise HBV vaccine <input type="checkbox"/> Substance abuse <input type="checkbox"/> Domestic abuse <input type="checkbox"/> Return for test results/follow-up: 1 week <input type="checkbox"/> Chlamydia re-screen 6-12 months (age <25) <input type="checkbox"/> HIV re-screen 3-6 months <input type="checkbox"/> Referral: _____ <input type="checkbox"/> Other: _____ <input type="checkbox"/> Refer to NAP for quick oral HIV testing

COMMENTS

STUDENT: _____ **FACULTY:** _____ **DATE:** _____