

Interview Record for Gonorrhea/Chlamydia

Patient ID	Condition(s)	ReInfect.? If yes, #	Case ID	Interview Record ID	
<input style="width: 100%;" type="text"/>	1 <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input style="width: 20px;" type="text"/>	1 <input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	Patient Name
	2 <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input style="width: 20px;" type="text"/>	2 <input style="width: 100%;" type="text"/>		

Name	Demographics
Last Name <input style="width: 60%;" type="text"/> First Name <input style="width: 20%;" type="text"/> Middle Name <input style="width: 20%;" type="text"/> Preferred Name / AKA <input style="width: 60%;" type="text"/> Maiden Name <input style="width: 40%;" type="text"/>	Date of Birth <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> Age <input style="width: 20px;" type="text"/> <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R Hispanic/Latino Race: <input type="checkbox"/> AI/AN <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> NH/PI <input type="checkbox"/> W <input type="checkbox"/> U <input type="checkbox"/> R Sex at Birth: <input type="checkbox"/> M <input type="checkbox"/> F Marital Status: <input type="checkbox"/> S <input type="checkbox"/> M <input type="checkbox"/> Sep <input type="checkbox"/> D <input type="checkbox"/> W <input type="checkbox"/> C <input type="checkbox"/> U <input type="checkbox"/> R
Address	Phone/Contact
Residence Street <input style="width: 60%;" type="text"/> (Apt. #) <input style="width: 20%;" type="text"/> City <input style="width: 20%;" type="text"/> State <input style="width: 20px;" type="text"/> Zip <input style="width: 20px;" type="text"/> County <input style="width: 20px;" type="text"/> District <input style="width: 20px;" type="text"/> Country <input style="width: 20px;" type="text"/> Living With <input style="width: 60%;" type="text"/> Residence Type <input style="width: 20px;" type="text"/> Time At Address <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Time In State <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Time In Country <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Currently Institutionalized? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U Name of Institution <input style="width: 60%;" type="text"/> Institution Type <input style="width: 20px;" type="text"/>	Home Phone <input style="width: 100%;" type="text"/> Work Phone <input style="width: 100%;" type="text"/> Cellular Phone <input style="width: 100%;" type="text"/> Emergency Contact <input style="width: 100%;" type="text"/> E-Mail Address(es) <input style="width: 100%;" type="text"/>

STD Testing	Pregnancy																				
<table border="0" style="width: 100%;"> <tr> <th>Date Collected</th> <th>Provider</th> <th>Test</th> <th>Specimen Source</th> <th>Qualitative Result</th> </tr> <tr> <td><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/></td> <td><input style="width: 60%;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U</td> </tr> <tr> <td><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/></td> <td><input style="width: 60%;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U</td> </tr> <tr> <td><input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/></td> <td><input style="width: 60%;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input style="width: 20px;" type="text"/></td> <td><input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U</td> </tr> </table>	Date Collected	Provider	Test	Specimen Source	Qualitative Result	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input style="width: 60%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input style="width: 60%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U	<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input style="width: 60%;" type="text"/>	<input style="width: 20px;" type="text"/>	<input style="width: 20px;" type="text"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U	Pregnant at Exam? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R # Weeks <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Pregnant in Last 12 Mos? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R
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STD Treatment		
Treatment Date	Provider	Drug and Dosage
<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input style="width: 60%;" type="text"/>	<input style="width: 100%;" type="text"/>
<input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	<input style="width: 60%;" type="text"/>	<input style="width: 100%;" type="text"/>
Treatment Comments: <input style="width: 60%;" type="text"/> Provider Choice: <input style="width: 40%;" type="text"/>		

Risk Factors	Y - Yes N - No R - Refused to Answer D - Did not Ask
In the last 12 months has the patient: 1. Had sex with a male? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D 2. Had sex with a female? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D 3. Had sex with an anonymous partner? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D 4. Been incarcerated? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D 5. During the past 12 months, which of the following injection or non-injection drugs have been used? None <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Other, specify: <input style="width: 60%;" type="text"/>	Crack <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Methamphetamines <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Cocaine <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Nitrates/Poppers <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Heroin <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D Erectile dysfunction medications (e.g., Viagra) <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> R <input type="checkbox"/> D

Reporting Information	Condition 1	Condition 2
	Method of Case Detection <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Facility First Tested <input style="width: 60%;" type="text"/> Other <input style="width: 20px;" type="text"/> Interview Period (mos.) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> If Other, Describe <input style="width: 60%;" type="text"/> Laboratory Report Date <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>	Method of Case Detection <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Facility First Tested <input style="width: 60%;" type="text"/> Other <input style="width: 20px;" type="text"/> Interview Period (mos.) <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> If Other, Describe <input style="width: 60%;" type="text"/> Laboratory Report Date <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
	Date First Assigned for Interview <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> Worker <input style="width: 60%;" type="text"/> Date Original Interview <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> Worker <input style="width: 60%;" type="text"/>	Worker <input style="width: 60%;" type="text"/> Supervisor # <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Date Case Closed <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>
	Date First Assigned for Interview <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> Worker <input style="width: 60%;" type="text"/> Date Original Interview <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> Worker <input style="width: 60%;" type="text"/>	Worker <input style="width: 60%;" type="text"/> Supervisor # <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> Date Case Closed <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/> / <input style="width: 20px;" type="text"/>

Local Use: A B C D E F G H I J K L

Patient Name

Case ID

HIV Testing

Tested for HIV at this event? Y N U R Not Asked Previously Tested for HIV? Y N U R Not Asked

Date Collected _____ Provider _____ Test _____ Specimen Source Qualitative Result P N I U Q C Provider Confirmed

Signs and Symptoms

STD History

Interview Period Partners

Signs/Symptoms Earliest Observation Date Anatomic Site Duration (Days)
1. [] / / []
2. [] / / []
3. [] / / []
If Other, Please Describe: _____

Previous STD History? Y N U R
Condition Dx Date (mm/yyyy) Rx Date (mm/yyyy)
1. [] / []
2. [] / []
3. [] / []

Unknown Refused
Female [] [] [] U R
Male [] [] [] U R
1
Female [] [] [] U R
Male [] [] [] U R
2

Partner/Cluster Information

1 Last Name First Name AKA Jurisdiction
P/CL First Exposure Freq. Last Exposure Sex M F T U R Pregnant Y N U R Spouse Y N U R
Condition 1 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #
Condition 2 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #

2 Last Name First Name AKA Jurisdiction
P/CL First Exposure Freq. Last Exposure Sex M F T U R Pregnant Y N U R Spouse Y N U R
Condition 1 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #
Condition 2 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #

3 Last Name First Name AKA Jurisdiction
P/CL First Exposure Freq. Last Exposure Sex M F T U R Pregnant Y N U R Spouse Y N U R
Condition 1 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #
Condition 2 Ix Date Init. Date Ix DIS # Ix Type Referral FR# Dispo Dispo Date Cond. DIS #

Social History

Interview, Internet, and Investigation Comments

Places Met Partners Places Had Sex
Type Name Type Name
[] [] [] []
[] [] [] []
[] [] [] []
[] Did not ask [] Did not ask
[] Refused to answer [] Refused to answer

Interview, Internet, and Investigation Comments

Incidental Antibiotic Treatment in Last 12 Months? Y N U

Rx Date (mm/yyyy) Drug/Dosage/Duration Condition
/ /
/ /