Interview Record for Gonorrhea/Chlamydia

Patient ID | Condition(s) | ReInfection? If yes, # | Case ID | Interview Record ID

1 [ ] [ ] [ ] Y N U [ ] 1 [ ]
2 [ ] [ ] [ ] Y N U [ ] 2 [ ]

Patient Name

Case ID

Name

Last Name | First Name | Middle Name

Preferred Name / AKA | Maiden Name

Demographics

Date of Birth / / | Age [ ] [ ] | Hispanic/Latino: Y N U R

Sex at Birth: M F

Race: AI/AN A B NH/PI W U R

Marital Status: S M Sep D W C U R

Address

Residence Street | (Apt. #) | City

State | Zip | County | District | Country

Living With | Residence Type [ ]

Time At Address [ ] W M Y | Time In State [ ] W M Y | Time In Country [ ] W M Y

Currently Institutionalized? Y N U | Name of Institution | Institution Type [ ]

Phone/Contact

Home Phone

Work Phone

Cellular Phone

Emergency Contact

E-Mail Address(es)

STD Testing

Date Collected	Provider	Test	Specimen Source	Qualitative Result
/ /			[ ]	P N I U
/ /			[ ]	P N I U
/ /			[ ]	P N I U

Pregnancy

Pregnant at Exam? Y N U R

[ ] [ ] # Weeks

Pregnant in Last 12 Mos? Y N U R

STD Treatment

Treatment Date	Provider	Drug and Dosage
/ /		
/ /		

Treatment Comments: _____ **Provider Choice:** _____

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? Y N R D
2. Had sex with a female? Y N R D
3. Had sex with an anonymous partner? Y N R D
4. Been incarcerated? Y N R D
5. During the past 12 months, which of the following injection or non-injection drugs have been used? Y N R D

None

Please place an "X" for all that apply:

- ☐ Crack
- ☐ Cocaine
- ☐ Heroin
- ☐ None
- ☐ Methamphetamines
- ☐ Nitrates/Poppers
- ☐ Erectile dysfunction medications (e.g., Viagra)
- ☐ Other

Other, specify: _____

Reporting Information Condition 1

Method of Case Detection [ ] [ ] | Other | Interview Period (mos.)

Facility First Tested [ ] | If Other, Describe | Laboratory Report Date / /

Date First Assigned for Interview / / | Worker | Date Original Interview / / | Worker

Worker | Supervisor # | / / Date Case Closed

Reporting Information Condition 2

Method of Case Detection [ ] [ ] | Other | Interview Period (mos.)

Facility First Tested [ ] | If Other, Describe | Laboratory Report Date / /

Date First Assigned for Interview / / | Worker | Date Original Interview / / | Worker

Worker | Supervisor # | / / Date Case Closed

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

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	Provider Confirmed
/ /				P N I U Q C	

Signs and Symptoms

	Signs/ Symptoms	Earliest Observation Date	Anatomic Site	Duration (Days)
1.		/ /		
2.		/ /		
3.		/ /		

If Other, Please Describe:

STD History

Previous STD History? Y N U R

	Condition	Dx Date (mm/yyyy)	Rx Date (mm/yyyy)
1.		/	/
2.		/	/
3.		/	/

Interview Period Partners

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

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

	Ix Date	Init. Date	Ix DIS #	Ix Type	Referral 1 2 3	FR#	Dispo	Dispo Date	Cond.	DIS #
Condition 1	/ /	/ /						/ /		
Condition 2	/ /	/ /						/ /		

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

	Ix Date	Init. Date	Ix DIS #	Ix Type	Referral 1 2 3	FR#	Dispo	Dispo Date	Cond.	DIS #
Condition 1	/ /	/ /						/ /		
Condition 2	/ /	/ /						/ /		

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

	Ix Date	Init. Date	Ix DIS #	Ix Type	Referral 1 2 3	FR#	Dispo	Dispo Date	Cond.	DIS #
Condition 1	/ /	/ /						/ /		
Condition 2	/ /	/ /						/ /		

Social History

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**
/		
/		