SUPPLEMENTARY STI PATIENT INTERVIEW FORM

South Dakota Department of Health – Office of Disease Prevention and Health Promotion

For further assistance, please contact the closest regional field office by visiting our website at: https://doh.sd.gov/topics/sexual-health-prevention/hivsti-testing-sites/.
This form is for investigation purposes only and supplementary information may be faxed to (605) 773-5509. **Please go to https://doh.sd.gov/topics/diseases-conditions/communicable-infectious-diseases/reportable-communicable-diseases/ for online disease reporting.**

Patient Information

Last Name: _____ **First Name:** _____ **Alias:** _____

Date of Birth: _____ **Address:** _____ **Apt. /Lot #** _____

City: _____ **State:** _____ **County:** _____ **Phone:** _____

Race: ☐ American Indian/Alaskan Native ☐ White ☐ Black/African American ☐ Asian/Pacific Islander ☐ Other _____

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Gender at Birth:** ☐ Male ☐ Female **Current Gender:** ☐ Male ☐ Female

Sexual Orientation: ☐ Straight ☐ Gay/Lesbian ☐ Bisexual ☐ Something Else ☐Unknown

Pregnant? ☐ Unknown ☐ No ☐ Yes **# of Wks** _____ **# of Past Pregnancies** _____ **Last menstrual cycle** _____

Risk Factors

Known exposure to a STI? Date: _____ ☐ Chlamydia ☐ Gonorrhea ☐Syphilis ☐ HIV/AIDS ☐ Other: _____

Number of partners in the past 12 months: Male _____ Female _____ Transgender _____

☐ (Women only) Sex with a person who is known to her to be an MSM? ☐ Anonymous sexual partners #_____

☐ Met through Internet/social media _____ ☐ Sex while high/intoxicated

☐ Ever been incarcerated ☐ Sex for drugs, money, or a place to stay ☐ Sex without a condom ☐ Sex with IV drug user

☐ Engaged in drug use (Crack, Cocaine, Heroin, Meth, Nitrates/Poppers, Erectile Dysfunction etc.) Route of Administration: ☐ Non-injection ☐ Injection

Symptoms

☐ Asymptomatic ☐ Rash ☐ Alopecia (hair loss) ☐ Condyloma Lata ☐ Swelling/Inflammation ☐ Swollen lymph nodes

☐ Mucous Patch ☐ Chancre/Sores/Lesions/Ulcers ☐ Abdominal Pain ☐ Vaginal/Penile Discharge ☐ Testicular Pain

☐ Manifestations (Neurologic, Ocular, Otic, Late Clinical): _____ ☐ Other: _____

Location of symptoms: ☐ Anus/Rectum ☐ Penis ☐ Scrotum ☐ Vagina ☐ Cervix ☐ Nasopharynx ☐ Eye/Conjunctiva
☐ Mouth/Oral Cavity ☐ Head ☐ Torso ☐ Extremities (arms, legs, hands, feet) ☐ Other: _____ ☐ Unknown

Date of onset of first symptom: _____

Reporting Facility: _____ Provider: _____

Testing & Treatment

Chlamydia: Date Collected: _____ ☐ Negative ☐ Positive ☐ Invalid ☐ Not Tested

Treatment: ☐ Doxycycline (100mg PO BID for 7 days) ☐ Azithromycin (1g PO x1) Date Administered _____ ☐ Not treated

Gonorrhea: Date Collected: _____ ☐ Negative ☐ Positive ☐ Invalid ☐ Not Tested

Treatment: ☐ Rocephin (500mg IM <300lbs.) ☐ Rocephin (1000mg IM >300lbs.) Date Administered _____ ☐ Not treated

Syphilis: Previous Positive? ☐ No ☐ Yes Previously treated date: _____ Known Penicillin allergy? ☐ No ☐ Yes

Syphilis Rapid Test: Date Collected: _____ ☐ Non-reactive ☐ Reactive ☐ Invalid ☐ Not Tested

Nontreponemal: Date Collected: _____ ☐ Non-reactive ☐ Reactive ☐ Invalid ☐ Not Tested **Titer** _____

Treponemal: Date Collected: _____ ☐ Non-reactive ☐ Reactive ☐ Invalid ☐ Not Tested

Treatment: ☐ Bicillin (2.4mu IM x1) ☐ Bicillin (2.4mu IM x1 for 3 weeks) ☐ **Alternative treatment/dosage:** _____

Date Administered _____ ☐ Not treated

HIV Rapid Test: Date Collected: _____ ☐ Non-reactive ☐ Reactive ☐ Invalid ☐ Not Tested

HIV Confirmatory: Date Collected: _____ ☐ Non-reactive ☐ Reactive ☐ Invalid ☐ Not Tested

If HIV results not given, why? ☐ Declined notification ☐ Could not locate ☐ Other: _____

Original Patient's Name: ____**Date of Birth:** __________________

List sexual and needle sharing partners from the past two months, including as much information about that person. If you have not had any partners in the last two months, list the last sexual or needle sharing partner. By providing partner information, we may not need to contact you further. If positive, we will contact partners confidentially and inform them of the benefits of testing or treatment for STIs. **We do not disclose client identity or any personal or medical information to partners.**

Last Name: ______________________________________ **First Name:** ______________________________________

Date of Birth: __________________ *or* **Approximate Age:** _________ **Nickname:** ____________________________

Address: ____ **Apt. /Lot #** ________________

City: ______________________________________ **State:** _________ **County:** ______________________________

Phone: ____________________________________ **Facebook Username:** ___________________________________

First Exposure Date: ______/_______/_______ **Last Date Exposure:** ______/_______/_______

Gender: ☐ Male ☐ Female **Is this partner pregnant?** ☐ Unknown ☐ No ☐ Yes # of Wks ___________

Race: ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Other ________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Type of Contact:** ☐ Vaginal Sex ☐ Anal Sex ☐ Oral Sex ☐ Needle-Sharing

Communicate via social media: ☐ Facebook ☐ Instagram ☐ Snapchat ☐ Tinder ☐ Grindr ☐ Other: ____________

Social Media Username: ____________________________ **Best way to contact:** ______________________________

Last Name: ______________________________________ **First Name:** ______________________________________

Date of Birth: __________________ *or* **Approximate Age:** _________ **Nickname:** ____________________________

Address: ____ **Apt. /Lot #** ________________

City: ______________________________________ **State:** _________ **County:** ______________________________

Phone: ____________________________________ **Facebook Username:** ___________________________________

First Exposure Date: ______/_______/_______ **Last Date Exposure:** ______/_______/_______

Gender: ☐ Male ☐ Female **Is this partner pregnant?** ☐ Unknown ☐ No ☐ Yes # of Wks ___________

Race: ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Other ________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Type of Contact:** ☐ Vaginal Sex ☐ Anal Sex ☐ Oral Sex ☐ Needle-Sharing

Communicate via social media: ☐ Facebook ☐ Instagram ☐ Snapchat ☐ Tinder ☐ Grindr ☐ Other: ____________

Social Media Username: ____________________________ **Best way to contact:** ______________________________

Last Name: ______________________________________ **First Name:** ______________________________________

Date of Birth: __________________ *or* **Approximate Age:** _________ **Nickname:** ____________________________

Address: ____ **Apt. /Lot #** ________________

City: ______________________________________ **State:** _________ **County:** ______________________________

Phone: ____________________________________ **Facebook Username:** ___________________________________

First Exposure Date: ______/_______/_______ **Last Date Exposure:** ______/_______/_______

Gender: ☐ Male ☐ Female **Is this partner pregnant?** ☐ Unknown ☐ No ☐ Yes # of Wks ___________

Race: ☐ Asian/Pacific Islander ☐ American Indian/Alaskan Native ☐ Black/African American ☐ White ☐ Other ________

Ethnicity: ☐ Hispanic ☐ Non-Hispanic **Type of Contact:** ☐ Vaginal Sex ☐ Anal Sex ☐ Oral Sex ☐ Needle-Sharing

Communicate via social media: ☐ Facebook ☐ Instagram ☐ Snapchat ☐ Tinder ☐ Grindr ☐ Other: ____________

Social Media Username: ____________________________ **Best way to contact:** ______________________________

Please use additional sheets for additional sexual partners.