

## 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.** 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: \_\_\_\_\_

### Testing & Treatment

**Chlamydia:** Date Collected: \_\_\_\_\_  Negative  Positive  Not Tested  
**Treatment:**  Doxycycline (100mg PO BID for 7 days)  Azithromycin (1mg PO x1) Date Administered \_\_\_\_\_  Not treated

**Gonorrhea:** Date Collected: \_\_\_\_\_  Negative  Positive  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  Not Tested **Titer** \_\_\_\_\_: \_\_\_\_\_  
**Treponemal:** Date Collected: \_\_\_\_\_  Non-reactive  Reactive  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: \_\_\_\_\_

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