

Indian Health Service

Taking A Sexual History

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Sexual Health History: Techniques and Tips

- Use a proactive, integrated, patient-centered approach to sexual health that includes but is not limited to, disease identification and treatment.
- Deliver positive, affirming, nonjudgmental sexual health care by intentionally creating safe spaces for all patients.
- Identify individual implicit bias around sexuality and sexual topics, adverse childhood experiences, and trauma-informed care.
- Models such as the 5 or 6 Ps can help physicians organize their approach to sexual health histories.



The Ps:

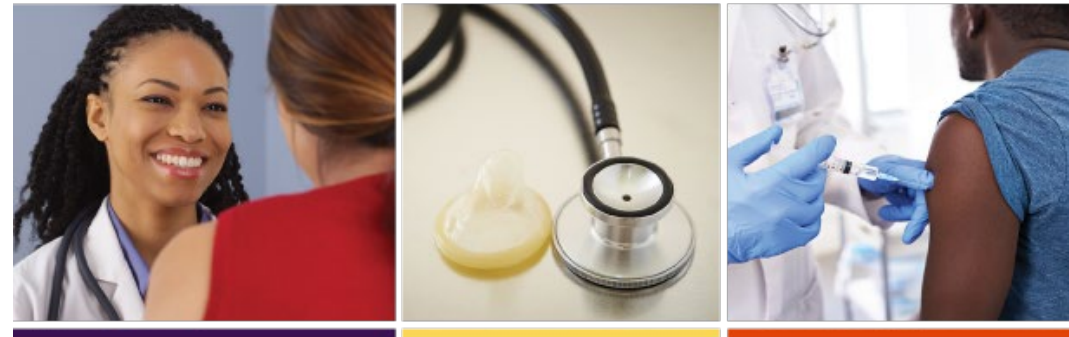
- 1) Permission and Pronouns
- 2) Partners
- 3) Practices
- 4) Past History of STIs
- 5) Protection
- 6) Pregnancy

Taking a Sexual Health History

- Begin the conversation by intentionally asking patients for permission to talk about sexual health.
- Use a proactive sexual history to discuss and address sexual health during office visits allows patients an opportunity to share their concerns or ask questions without the embarrassment of needing to raise the topic first.^{2,8}

Nusbaum MR, Hamilton CD. The proactive sexual health history. *Am Fam Physician*. 2002;66(9):1705-1712. Accessed June 16, 2024. <https://www.aafp.org/afp/2002/1101/p1705.html>

Sexual Health and Your Patients: A Provider's Guide



Key Points to Ensure a Productive Sexual Health Conversation

Avoid moral or religious judgment of the patient's behavior

Avoid terms that make assumptions about sexual behavior or orientation (e.g., “How many partners have you had in the past year?” vs. “Are you monogamous?”)

Establish rapport and consent before addressing sensitive topics

Use a sensitive tone that normalizes the topics you are discussing

Respect the patient's right to decline to answering questions or sharing information

Use neutral and inclusive terms that avoid assumptions about orientation (e.g., partner)

Permission and Pronouns

- Ask what your patient's preferred pronouns are and what their gender identity is.
- “One part of your health history I want to discuss further is your sexual health. It's an important part of your overall health as we want to make sure we are safe and protecting against any infections. Can I ask you questions about your sexual health?”
- “The questions I ask are questions I ask to all of my patients. Our discussion will be confidential and kept between us. Do you have any questions or concerns before we start?”

Partners

- Do not assume a person's sexual orientation based on their practices or vice versa – see our information on ensuring cultural safety in relationships
- “Tell me about your partners?”
- Are you in a relationship with them?
- Do you feel safe in this relationship?”
- How many partners have you had in the past month? The past six months? Your lifetime?

Practices

- Are you currently sexually active?”
 - If no: “Have you ever been sexually active?”
- “What kind of sex do you have/have you had in the past year?”
 - E.g. Vaginal, anal, oral, manual stimulation of penis/vagina/anus
- “Do you exchange sex for food, shelter, substances, or money?”
- “Have you ever been hurt or felt unsafe when having sex?”
- “Have you ever had sex while under the influence?”



Past
history/protection
from sexually
transmitted diseases
and sexually
transmitted
infections

- Have you ever had any sex-related diseases?
- What do you know about protecting yourself STIs and HIV?
 - “Is there anything you and your partner(s) use for protection?”
 - E.g. condoms, dental dams, split condoms/gloves
 - “How often is it used and for what kind of intercourse?”
- Have you ever been tested for STIs and HIV? Would you like to be?
- Have you been vaccinated for HPV, Hepatitis A, and/or Hepatitis B?”

3) Protection

- “Do you and your partner(s) discuss prevention of STIs and HIV?”
 - “Do you and your partner(s) discuss getting tested?”
 - “What protection methods do you use?”

Pregnancy plans

Are you trying
to become a
parent?

Would you like
to get
pregnant?

What method
do you use for
contraception?

Resources

- Sexual Health and Your Patients: A Provider's Guide
 - https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/asset/Provider-Guide_May-2022.pdf
- A New Approach to Sexual History Taking: A Video Series
 - <https://nationalcoalitionforsexualhealth.org/tools/for-healthcare-providers/video-series>
- A Guide to Taking a Sexual History
 - <https://www.cdc.gov/std/treatment/sexualhistory.pdf>



STI Treatment and Testing
Protocol example
Standing Orders



DEPARTMENT OF HEALTH AND HUMAN SERVICES

INDIAN HEALTH SERVICE
CROW/NORTHERN CHEYENNE SERVICE UNIT

Policy Number	Name of Policy Standing Order Sexually Transmitted Infection Treatment and Testing	Approved by: Date:
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PURPOSE / RATIONALE: To allow Public Health Nurses to provide rapid testing and treatment in an effort to decrease Sexually Transmitted Infections (STI's).

POLICY STATEMENT: The Public Health Nurse shall have an expedited means to treat individuals, ages 14 and up, and known contacts of Gonorrhea (GC), Chlamydia Trachomatis (CT); Syphilis, Trichomoniasis, and other sexually transmitted diseases. Upon identification of a positive case, the patient and or contact(s) will be treated by the Public Health Nurse per standing order which follow the Centers for Disease Control's most current treatment guidelines.

ASSESSMENT: *Criteria used to determine the situation or condition for which the standing order may be carried out.*

1. Subjective Findings:

- a. Report of signs and symptoms of sexually transmitted disease (STI)
 - i. All patients who have not seen by a provider will need to be scheduled for an appointment after appropriate treatment.
- b. And/or contact of verified case of STI

2. Objective Findings:

- a. Confirmatory Lab Testing

PLAN OF CARE:

1. Testing

- a. Patients may present to Public Health Nursing requesting STD testing.
- b. PHN's, during STD investigations, may need to test a contact
- c. Using the nursing process and Standing Orders for STD Treatment based on CDC STD treatment guidelines, PHN's may treat symptomatic patients at the time of testing.

2. Treatment:

Condition	Medication
CT or known contact of CT	1 GM Azithromycin PO x1
Uncomplicated GC or known contact to GC	Under 300 Pounds – 500 mg Ceftriaxone IM X1 300 Pounds and above – 1 GM Ceftriaxone IM X1 Expedited Partner Therapy – Cefixime 800mg PO once (If IM injection cannot be given)

Crow/Northern
Cheyenne policy,
page 1 of 3

If Chlamydia has not been excluded or co-infection of CT/GC	Under 300 Pounds – 500 mg Ceftriaxone IM X1 300 Pounds and above – 1 GM Ceftriaxone IM X1 Expedited Partner Therapy – Cefixime 800mg PO x 1 (If IM injection cannot be given) AND Doxycycline 100 mg PO BID x7 Days OR Azithromycin 1GM PO x 1 for allergies or concern for noncompliance
Co-infection GC/CT during pregnancy	Under 300 Pounds – 500 mg Ceftriaxone IM X1 300 Pounds and above – 1 GM Ceftriaxone IM X1 AND Azithromycin 1 GM IM X1
GC/CT Treatment with Cephalosporin Allergy	Gentamycin 240 mg IM AND Azithromycin 2GM PO X1
Trichomoniasis Vaginalis	Tinidazole 2GM PO X1
Syphilis	Penicillin G 2.4 million units IM x 1
Syphilis treatment with Penicillin Allergy (Non-pregnant)	Doxycycline 100mg PO BID x 14 Days
Syphilis treatment with Penicillin Allegery (Pregnant)	Refer to PCP for penicillin desensatization

PROCEDURE:

1. Upon identification of positive case by lab or MIDIS, the patient will be contacted and treated in either the Public Health Nurse office or the outpatient clinic.
2. The PHN will complete the commuicable disease investigation, including known contacts.
3. The PHN will contact all contacts and will test and treat them per CDC recommendations outlined in this policy.
4. Documentation in the electronic health record will include allergies, positive confirmatory testing, treatment administered and STI education.
5. Public Health Nurses **will contact pharmacy** to order medications under this standing order in E.H.R., with a designated provider as the ording provider, and the patient will be instructed to pick up the medication from the pharmacy or to report to the PHN office.
6. **Ordering pharmacist with enter a note in EHR inidcating why they ordered the medication and cosign the designated provider.**
7. Administration of a medication must be documented in the patient’s medical record by the licensed staff and must include name of medication, dosage, route, site, date and time of administration, effectiveness of medication/patient’s response to medication administration, and reference to this Standing Order and plan of care when applicable.
8. Outpatient pharmacy will be contacted to review for appropriateness process standing order and will “release without signature”.
9. Criteria for contacting the Primary Care Provider:
 - a. Signs and symptoms of severe local or system reaction to the antibiotic
 - b. Severe signs and symptoms of respective STI (unuals cases)
10. Follow-up Requirements:

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- b. Complete and submit positive STI investigation in MIDIS.

REFERENCES:

Montana Standards of Nursing Practice 24.159.1204
Centers for Disease Control Sexually Transmitted Infection Treatment Guidelines

STD Case Record Form

STD CASE RECORD FORM

Patient ID	Condition(s)	Reinfection? If yes, #	Case ID	Interview Record ID
1	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	1	
2	<input type="checkbox"/>	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U	2	

Name		Demographics	
Last Name	First Name	Middle Name	
Date of Birth		Age	Hispanic/Latino <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R
Sex of Birth		Gender	
Prof. Name / AKA		Maiden Name	
Address		Phone/Contact	
Residence Street	Unit #	City	Home Phone
State	Zip	County	Work Phone
			Mobile Phone
			Emergency Contact
			Mail Address(es)

Reporting Information		
Investigation Start Investigation Date:	Diagnosis Date:	Diagnosis Reported to CDC: 200-CT 300-GC
Date of Report:	Reporting County:	RID: N U Y
Earliest Date Report to County:	Confirmation Method:	Laboratory confirmed
Earliest Date Report to State:	Confirmation Date:	
Was patient hospitalized?: N U Y	Case Status:	

Case Management		
Patient Eligible for Notification of Exposure:	Disposition:	Date Assigned:
Investigator:	Disposition Date:	Patient Interview Status:
Date Assigned:	Disposition by:	Date Closed:
Exam Dt:	Supervisor:	Closed by:
Interviewer:		

Pregnancy		
Pregnant of Exam? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	Pregnant of Interview? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	Currently in Prenatal Care? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R
Pregnant in Last 12 Mo? <input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R		

RISK FACTORS		
Was behavioral risks assessed? <input type="checkbox"/> 1 Client completed a behavioral risk profile	5 Client was asked but no behavioral risks were identified	
66 Client was not asked about behavioral risk factors	77 Client declined to discuss behavioral risk factors	
Y-Yes, Anal or Vaginal Intercourse (with or without Oral Sex) O-Yes, Oral Sex Only U-Unspecified Type of Sex N-No R-Refused to Answer D-Did Not Ask		

Within the past 12 months has the patient:			
1. Had sex with a male?	<input type="checkbox"/>	6. Had sex while intoxicated and/or high on drugs?	<input type="checkbox"/>
2. Had sex with a female?	<input type="checkbox"/>	7. Exchanged drugs/money for sex?	<input type="checkbox"/>
3. Had sex with a transgender person?	<input type="checkbox"/>	8. [Females only] Had sex with a person who is known to her to be an MSM?	<input type="checkbox"/>
4. Had sex with an anonymous partner?	<input type="checkbox"/>	9. Had sex with a person known to him/her to be an IDU?	<input type="checkbox"/>
5. Had sex without using a condom?	<input type="checkbox"/>		

PATIENT TAB → CASE INFO TAB → CASE MANAGEMENT TAB → CORE INFO TAB →

Add New Interview				
Date of Interview:				
Interview Type: Initial/Original				
Interview Location: Clinic Field Telephone				
Were contacts named at this interview: N Y				

Partner Contact Information				
Partner Contact Tab ID	Name: Last	First	DOB or Age:	Gender: M F
Contact Record Tab ID Jurisdiction:	Relationship w/patient? This patient Processing Decision:	Named: PHN with date	Referral Basis: P1-Partner, Sex	Last Exposure Date:
Field (U)	Field (U)	Field (U)	Field (U)	Field (U)
Follow-up Investigation Tab ID	Investigation Start Date:	Date Assigned to Investigation:	Notifiable:	
Supplemental Info Tab (optional)				
Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:
Comments				

Partner Contact Information				
Partner Contact Tab ID	Name: Last	First	DOB or Age:	Gender: M F
Contact Record Tab ID Jurisdiction:	Relationship w/patient? This patient Processing Decision:	Named: PHN with date	Referral Basis: P1-Partner, Sex	Last Exposure Date:
Field (U)	Field (U)	Field (U)	Field (U)	Field (U)
Follow-up Investigation Tab ID	Investigation Start Date:	Date Assigned to Investigation:	Notifiable:	
Supplemental Info Tab (optional)				
Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:
Comments				

Partner Contact Information				
Partner Contact Tab ID	Name: Last	First	DOB or Age:	Gender: M F
Contact Record Tab ID Jurisdiction:	Relationship w/patient? This patient Processing Decision:	Named: PHN with date	Referral Basis: P1-Partner, Sex	Last Exposure Date:
Field (U)	Field (U)	Field (U)	Field (U)	Field (U)
Follow-up Investigation Tab ID	Investigation Start Date:	Date Assigned to Investigation:	Notifiable:	
Supplemental Info Tab (optional)				
Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:
Comments				

CONTACT RECORDS TAB-ADD INTERVIEW AND ADD NEW CONTACT RECORD

Y-Yes N-No R-Refused to Answer D-Did Not Ask				
Within the past 12 months has the patient:		13. During the past 12 months, which of the following injection or non-injection drugs have been used? (Y/N/R/D)		
10. Been incarcerated?	<input type="checkbox"/> Y/N/R/D	<input type="checkbox"/> None	<input type="checkbox"/> Nitrates/Poppers	<input type="checkbox"/> Methamphetamines
11. Engaged in injection drug use?	<input type="checkbox"/>	<input type="checkbox"/> Crack	<input type="checkbox"/> Cocaine	<input type="checkbox"/> Erectile dysfunction medications (e.g., Viagra)
12. Shared injection drug equipment?	<input type="checkbox"/>	<input type="checkbox"/> Heroin	<input type="checkbox"/>	<input type="checkbox"/> Other, specify: _____

Social History		Interview Period Partners	
Places Met Partners	Places Had Sex	Partners Past Year	Transgender Refused
Type Name Type Name	Type Name	Y N # Unknown Refused	Y N # Unknown Refused
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Female <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Female <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Male <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Male <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Unknown <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Refused to answer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	Refused to answer <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

Partner Internet Information	
Were any of the sex partners met through the internet within the last 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Refused to answer <input type="checkbox"/> Did not ask	

STD Testing				
Date Collected	Provider	Test	Specimen Source	Qualitative Result
/ /			<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U
/ /			<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U
/ /			<input type="checkbox"/>	<input type="checkbox"/> P <input type="checkbox"/> N <input type="checkbox"/> I <input type="checkbox"/> U

STD History	
Previous STD History? N Refused to Answer Y Unknown	

900 Partner Services Information-HIV Testing	
Refer for Test:	900 Test:
Referral Date:	900 Result:

STD Treatment	
Treatment Date	Provider
/ /	
	Drug and Dosage
	Azithromycin 1 gm X 1
	Ceftriaxone 250mg X 1
Treatment Comments:	Provider Choice:

CORE INFO TAB → SYPHILIS ONLY → MANAGE ASSOCIATIONS →

STD CASE RECORD FORM

Patient ID	Condition(s)	ReInfection? 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"/>	Y <input style="width: 20px;" type="text"/> N <input style="width: 20px;" type="text"/> U <input style="width: 20px;" type="text"/>	1 <input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>
	2 <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/> <input style="width: 20px;" type="text"/>	Y <input style="width: 20px;" type="text"/> N <input style="width: 20px;" type="text"/> U <input style="width: 20px;" type="text"/>	2 <input style="width: 100%;" type="text"/>	

Name	Demographics
<div style="display: flex; justify-content: space-between;"> <div style="width: 30%;"> <input style="width: 100%;" type="text"/> <small>Last Name</small> </div> <div style="width: 30%;"> <input style="width: 100%;" type="text"/> <small>First Name</small> </div> <div style="width: 30%;"> <input style="width: 100%;" type="text"/> <small>Middle Name</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 45%;"> <input style="width: 100%;" type="text"/> <small>Preferred Name / AKA</small> </div> <div style="width: 45%;"> <input style="width: 100%;" type="text"/> <small>Maiden Name</small> </div> </div>	<div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="width: 20%;"> <input style="width: 100%;" type="text"/> / <input style="width: 100%;" type="text"/> / <input style="width: 100%;" type="text"/> <small>Date of Birth</small> </div> <div style="width: 10%;"> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <small>Age</small> </div> <div style="width: 20%;"> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <small>Hispanic/Latino</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <small>Sex at Birth</small> </div> <div style="width: 40%;"> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <small>Race</small> </div> </div> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;"> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <input style="width: 100%;" type="text"/> <small>Mental Status</small> </div> </div>
Address	Phone/Contact
<div style="display: flex; justify-content: space-between; margin-bottom: 5px;"> <div style="width: 60%;"> <input style="width: 100%;" type="text"/> <small>Residence Street</small> </div> <div style="width: 10%;"> <input style="width: 100%;" type="text"/> <small>(Apt. #)</small> </div> <div style="width: 25%;"> <input style="width: 100%;" type="text"/> <small>City</small> </div> </div> <div style="display: flex; justify-content: space-between; margin-top: 10px;"> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <small>State</small> </div> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <small>Zip</small> </div> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <small>County</small> </div> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <small>District</small> </div> <div style="width: 15%;"> <input style="width: 100%;" type="text"/> <small>Country</small> </div> </div>	<input style="width: 100%;" type="text"/> <small>Home Phone</small> <input style="width: 100%;" type="text"/> <small>Work Phone</small> <input style="width: 100%;" type="text"/> <small>Cellular Phone</small> <input style="width: 100%;" type="text"/> <small>Emergency Contact</small> <input style="width: 100%;" type="text"/> <small>E-Mail Address(es)</small>

Reporting Information		
Investigation Start Investigation Date:	Diagnosis Date:	Diagnosis Reported to CDC: 200-CT 300-GC
Date of Report:	Reporting County:	PID: N U Y
Earliest Date Report to County:	Confirmation Method: Laboratory confirmed	
Earliest Date Report to State:	Confirmation Date:	
Was patient hospitalized?: N U Y	Case Status:	

PATIENT TAB ⇄

CASE INFO TAB ⇄

Case Management

Patient Eligible for Notification of Exposure:	Disposition:	Date Assigned:
Investigator:	Disposition Date:	Patient Interview Status:
Date Assigned:	Dispositioned by:	Date Closed:
Exam Dt:	Supervisor:	Closed by:
Interviewer:		

Pregnancy

Pregnant at Exam?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	<input type="text"/>	# Weeks	Pregnant at Interview?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	<input type="text"/>	# Weeks	Currently in Prenatal Care?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> U <input type="checkbox"/> R	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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RISK FACTORS

Was behavioral risks assessed?	<input type="checkbox"/>	1 Client completed a behavioral risk profile.	5 Client was asked but no behavioral risks were identified
		66 Client was not asked about behavioral risk factors	77 Client declined to discuss behavioral risk factors
Y-Yes, Anal or Vaginal Intercourse (with or without Oral Sex) O-Yes, Oral Sex Only U-Unspecified Type of Sex N-No R-Refused to Answer D-Did Not Ask			

Within the past 12 months has the patient:			
1. Had sex with a male?	<input type="checkbox"/>	6. Had sex while intoxicated and/or high on drugs?	<input type="checkbox"/>
2. Had sex with a female?	<input type="checkbox"/>	7. Exchanged drugs/money for sex?	<input type="checkbox"/>
3. Had sex with a transgender person?	<input type="checkbox"/>	8. [Females only] Had sex with a person who is known to her to be an MSM?	<input type="checkbox"/>
4. Had sex with an anonymous partner?	<input type="checkbox"/>	9. Had sex with a person known to him/her to be an IDU?	<input type="checkbox"/>
5. Had sex without using a condom?	<input type="checkbox"/>		

CASE MANAGEMENT TAB



CORE INFO TAB



Y- Yes N-No R-Refused to Answer D-Did Not Ask

Within the past 12 months has the patient:

10. Been incarcerated?

Y/N/R/D

11. Engaged in injection drug use?

12. Shared injection drug equipment?

13. During the past 12 months, which of the following injection or non-injection drugs have been used? (Y/N/R/D)

None

Crack

Cocaine

Heroin

Methamphetamines

Nitrates/Poppers

Erectile dysfunction medications (e.g., Viagra)

Other, specify: _____

Social History

Places Met Partners

Type	Name
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Refused to answer

Places Had Sex

Type	Name
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	_____
<input type="checkbox"/>	Unknown
<input type="checkbox"/>	Refused to answer

Interview Period Partners

	Partners Past Year			Transgender		
	Y	N	#	Unknown	Refused	
Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U	<input type="checkbox"/> R	1
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U	<input type="checkbox"/> R	

	Partners in 1x Period			Transgender		
	Y	N	#	Unknown	Refused	
Female	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U	<input type="checkbox"/> R	2
Male	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> U	<input type="checkbox"/> R	

Partner Internet Information

Were any of the sex partners met through the internet within the last 12 months?

Yes No Refused to answer Did not ask

STD Testing

Date Collected	Provider	Test	Specimen Source	Qualitative Result
____/____/____	_____	_____	<input type="text"/>	<input type="text"/> P <input type="text"/> N <input type="text"/> I <input type="text"/> U
____/____/____	_____	_____	<input type="text"/>	<input type="text"/> P <input type="text"/> N <input type="text"/> I <input type="text"/> U
____/____/____	_____	_____	<input type="text"/>	<input type="text"/> P <input type="text"/> N <input type="text"/> I <input type="text"/> U

SYPHILIS ONLY

STD History

Previous STD History? N Refused to Answer Y Unknown

900 Partner Services Information-HIV Testing

Refer for Test: _____ 900 Test: _____
 Referral Date: _____ 900 Result: _____

MANAGE ASSOCIATIONS: ⇄

STD Treatment

Treatment Date	Provider	Drug and Dosage
____/____/____	_____	Azithromycin 1 gm X 1
____/____/____	_____	Ceftriaxone 250mg X 1

Treatment Comments: _____ Provider Choice: _____

Add New Interview

Date of Interview:

Interview Type: Initial/Original

Interview Location: Clinic Field Telephone

Were contacts named at this interview: N Y

Partner/Contact Information

Partner	Contact Tab↔	Name: Last	First	DOB or Age:	Gender: M F	
	Contact Record Tab↔	Jurisdiction:	Relationship w/patient? This patient Processing Decision: Field f/u	Named: PHN with date	Referral Basis: P1-Partner, Sex	Last Exposure Date:
	Follow-up Investigation Tab↔	Investigation Start Date:	Date Assigned to Investigation:		Notifiable:	
Supplemental Info Tab (optional)						
	Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:	
Comments						

Partner	Contact Tab↔	Name: Last	First	DOB or Age:	Gender: M F	
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Supplemental Info Tab (optional)						
	Exam Date:	Disposition:	Disposition Date:	Disposition By:	Supervisor:	
Comments						

CONTACT RECORDS TAB-ADD INTERVIEW AND ADD NEW CONTACT