DCS PATIENT SELF-HISTORY FORM

CONFIDENTIAL

If you are unsure about any question, leave it blank and ask the nurse for help.

For office use only: ☐ New Patient ☐ Established	LABEL

Name: _____ DOB: _____ Age: _____ Height: _____

Cell Phone #: ( )_____ Work Phone #: ( )_____Email Address: _____

Emergency Contact Name: _____ Phone #: ( )_____

How did you hear about Health Department: ☐ Internet ☐ Friend/Family ☐ Other: _____

Reason for your visit today (**Please give details)**: _____

_____

Are you currently taking antibiotics? ☐Yes ☐No

Did you drink alcohol in the last 24 hours ☐Yes ☐ No

Drug Allergies: ☐ Yes ☐ No If Yes, please list name of drug(s) _____

Are you having any of the following problems (check all that apply)?

☐ Yes ☐ No Just want screening/testing – No problems

☐ Yes ☐ No Told to get tested ☐ Doctor ☐ Health Dept (call, letter, text, email) ☐ Partner

☐ Yes ☐ No Exposed to (partner has) ☐ Chlamydia ☐ Trich ☐ Gonorrhea ☐ Syphilis ☐ HIV ☐ Other_____

☐ Yes ☐ No Discharge or drip from **penis**: ☐Green ☐Yellow ☐White ☐Clear How long_____

☐ Yes ☐ No Discharge from **vagina**: ☐Green ☐Yellow ☐White ☐Clear How long_____

☐ Yes ☐ No Foul smelling discharge from vagina How long_____

☐ Yes ☐ No Lower abdominal pain ☐ Mild ☐Moderate ☐Severe How long_____

☐ Yes ☐ No Skin Rash/Sores/Lesions Where_____ How long_____

☐ Yes ☐ No Burning when urinating/peeing ☐ Mild ☐Moderate ☐Severe How long_____

☐ Yes ☐ No Painful during sex ☐ Mild ☐Moderate ☐Severe How long_____

☐ Yes ☐ No Pain in testicle/scrotal area/any swelling ☐ Mild ☐ Moderate ☐Severe How long____

☐ Yes ☐ No Irregular Bleeding ☐ Light ☐Moderate ☐Severe How long_____

☐ Yes ☐ No Other: _____

Patient Signature: _____ **Date:** _____

Reviewed By: _____ **Date:** _____

Comments _____

_____