



## CHLAMYDIA/GONORRHEA PATIENT INTERVIEW

NORTH DAKOTA DEPARTMENT OF HEALTH  
DIVISION OF DISEASE CONTROL  
SFN 61113 (08-2016)

You are being tested and/or treated for a sexually transmitted disease (STD). It is important for your health that your sexual partners are also treated for this infection. Sex partners and people infected with STDs may not know they are infected because many time people do not have symptoms, or only mild symptoms. It is important that **ALL** of your current and former sex partners are treated to prevent you from becoming reinfected, and to protect others from being infected.

Your name will never be used if the North Dakota Department of Health or your healthcare provider refers your partners in for testing and treatment. Your information is strictly confidential.

Please list all of the people you have had sex with in the last 3 months. If you have not had sex in the last 3 months, list your last sex partner. Please provide as much information as you can.

**It is essential you wait seven (7) days after you and your partner have been treated before you have sex again. Do not have sex again with your current partner until they have been treated.**

### Patient Information:

First Name:		Last Name:		Date of Birth:	
Street Address:		City:	State:	ZIP Code:	Telephone Number:
Race: <input type="checkbox"/> American Indian/Alaskan Native <input type="checkbox"/> Asian <input type="checkbox"/> Black/African American <input type="checkbox"/> Native Hawaiian/Pacific Islander <input type="checkbox"/> White <input type="checkbox"/> Refused				Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Not Hispanic or Latino <input type="checkbox"/> Refused	
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female		Pregnancy Status: <input type="checkbox"/> Not Pregnant <input type="checkbox"/> Pregnant <input type="checkbox"/> NA		If Pregnant, Due Date:	

### Risk History Information:

Are you a resident/staff member of correctional facility?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used intravenous/injection drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever used non-injection drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had sex while high/intoxicated?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had sex with an injection drug user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever traded sex for drugs or money?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever had sex with an anonymous sex partner?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever met sexual partners on the internet?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Total number of sex partners in last 12 months:	
Number of Female Partners	
Number of Male Partners	
How frequently does the patient use condoms during sex?	<input type="checkbox"/> Always <input type="checkbox"/> Not that Often <input type="checkbox"/> Never <input type="checkbox"/> Most of Time

**Sex Partner History\*** *Please list all information on any sexual partners within the last 90 days or the last sexual partner if exposure greater than 90 days ago.*

<b>Partner Name:</b>		<b>Date of Birth or Approximate Age:</b>		<b>Gender:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Address:</b>		<b>City:</b>	<b>State:</b>	<b>Telephone Number:</b>	
<i>Email Address and/or Username (Facebook, Twitter, Instagram, Snapchat, etc.)</i>					
<b>Date of First Exposure:</b>			<b>Frequency of Exposure:</b>		
<b>Date of Last Exposure:</b>			<b>Note for Exposure Dates:</b> <i>Include approximate dates if exact date unknown.</i>		
<i>Any notes about this person if name and location are unknown:</i>					
<b>Choose one of the following:</b> <input type="checkbox"/> This partner is here with me and is being treated today. <input type="checkbox"/> I will bring my current partner with me to the clinic. <input type="checkbox"/> I will contact this partner and refer them to the clinic. <input type="checkbox"/> I have no way of contacting this partner.			<b>If partner is a female, is she pregnant?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		
<b>For Provider Use:</b>					
<b>Was this partner tested?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No			<b>Partner Treatment Type:</b>		
<b>Partner Specimen Collection Date:</b>			<b>Partner Treatment Date:</b>		
<b>Partner Results:</b>			<b>Was partner treated via EPT?</b> <input type="checkbox"/> Yes <input type="checkbox"/> No		

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\*Please see page 4 for additional space if needed.

**This section is to be completed by the healthcare provider.**

**Provider Information**

Reportable Condition: <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea	
Diagnosing HealthCare Provider:	
Facility:	Telephone Number:
Specimen Source: <input type="checkbox"/> Urine <input type="checkbox"/> Cervix <input type="checkbox"/> Rectum <input type="checkbox"/> Pharyngeal	Specimen Collection Date:
Testing Laboratory:	

**Treatment Information**

Was treatment given for this infection? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>Chlamydia:</b> <input type="checkbox"/> 1g Azithromycin <input type="checkbox"/> 100mg Doxycycline BID x 7 days	<b>Gonorrhea:</b> <input type="checkbox"/> 250mg IM Ceftriaxone & 1g Azithromycin <input type="checkbox"/> 400mg Cefixime & 1g Azithromycin
Alternate therapy?	Were both doses observed? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Clinical History**

Reason Test Conducted: <input type="checkbox"/> Infection <input type="checkbox"/> Screen <input type="checkbox"/> Partner Referral		
Were symptoms noted? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, onset date:	Please note symptoms:
Was PID diagnosed? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Was case tested for HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Collection Date:	Result: <input type="checkbox"/> Positive <input type="checkbox"/> Negative

**Additional Sex Partner History**

<b>Partner Name:</b>		<i>Date of Birth or Approximate Age:</i>		<i>Gender:</i> <input type="checkbox"/> Male <input type="checkbox"/> Female	
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<i>Partner Results:</i>			<i>Was partner treated via EPT?</i> <input type="checkbox"/> Yes <input type="checkbox"/> No		

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Please Fax Completed Forms to 701.328.0355. Questions Contact NDDoH at 701.328.2378.

Revised: 08/2016

