Public Health
Prevent. Promote. Protect.
Portland Public Health Division
City of Portland, Health and Human Services Department

Date _____ ID # _____

For Office Use: PLACE STICKER HERE

1. What brings you to the clinic today? (Check all that apply.)

☐ I would like a check up.
☐ I have new partner(s).
☐ I am having symptoms.
☐ Interested in PrEP
☐ My partner(s) is/are having symptoms.
☐ My partner(s) tested positive for an STD.
☐ I was invited by STD staff.
☐ On PrEP, follow up
☐ Start PrEP process today
☐ Other_____

2. Are you having any of the following symptoms?

Please check **yes or no** for each symptom. **IF YES**, indicate duration and date last experienced.

Symptoms				
Yes	No		Duration	Date Last Experienced
☐	☐	Sores or bumps on your genitals		
☐	☐	Pain or burning during urination		
☐	☐	Body Rash (itching)		
☐	☐	My partner tested positive for an STD		
☐	☐	Diarrhea		
Male Genital Symptoms				
☐	☐	Discharge from penis		
☐	☐	Pain or discomfort in genital area		
☐	☐	Pain with ejaculation (when you come)		
☐	☐	Rectal pain		
☐	☐	Difficulty with urine stream		
☐	☐	Other		
Female Genital Symptoms				
☐	☐	Unusual vaginal discharge/odor		
☐	☐	Vaginal itching or burning		
☐	☐	Frequent urinations		
☐	☐	Abdominal or back pain		
☐	☐	Pain or bleeding with intercourse		

***IF you are experiencing symptoms AND have tried to treat yourself, what have you used?**

_____

3. Condom use. On a scale of zero to ten how often do you use condoms for sex? Please circle one number for each.

	Never					Sometimes						Always
Oral	NA	0	1	2	3	4	5	6	7	8	9	10
Anal	NA	0	1	2	3	4	5	6	7	8	9	10
Vaginal	NA	0	1	2	3	4	5	6	7	8	9	10

4. Please check/list any medications used in the past 30 days.

☐ Antibiotics ☐ Truvada as PrEP ☐ HIV medication ☐ Suboxone/Methadone
☐ Other (Please list **ALL** medications/drugs): _____

5. Do you have any known drug allergies? If yes, please list them below.

Drug Allergies

6. Do you have any ongoing medical conditions, including: asthma, diabetes, high blood pressure, depression, Hepatitis C, HIV, etc.? If yes, please list them below.

Ongoing Medical Conditions

FOR MALE ANATOMY:
7. Do you have a history of Prostatitis? ☐ Yes ☐ No

FOR FEMALE ANATOMY:
8. When was your last menstrual cycle (period)? _____ **9.** Was it normal? ☐Yes ☐No
10. When was your last pap smear? _____
11. Is there any possibility you are pregnant? ☐Yes ☐No

12. Have you ever been diagnosed with any of the following?
If yes, please indicate the date of infection and any treatment you received, if known.

Prior Medical History					
Yes	**No**	**Don't Know**	**Diagnosis**	**Date of Infection**	**Treatment**
☐	☐	☐	NGU		
☐	☐	☐	Chlamydia		
☐	☐	☐	N. Gonorrhea		
☐	☐	☐	Scabies		
☐	☐	☐	HPV		
☐	☐	☐	Herpes		
☐	☐	☐	Syphilis		
☐	☐	☐	HIV		
☐	☐	☐	Hepatitis A/B/C		
☐	☐	☐	Trichomonas		