Providence HEALTH CARE

IMMUNODEFICIENCY CLINIC
MALE SEXUAL HEALTH SCREEN

Date: _____

EXAMINATION

Lymph Nodes
- ☐ NAD
- ☐ Raised and tender

Mouth
- ☐ NAD
- ☐ Oral Candida
- ☐ Oral Hairy leukoplakia
- ☐ Ulcers
- ☐ Pharyngeal redness
- ☐ Pharyngeal exudate

Penis
- ☐ NAD
- ☐ Dry
- ☐ Moist
- ☐ Discharge
- ☐ Warts
- ☐ Ulcers
- ☐ Molluscum contagiosum
- ☐ Other: _____

Last void: _____

Testes
- ☐ NAD

Self examination:
☐ Yes ☐ No ☐ leaflet

Lumps
☐ Yes ☐ No

Perianal
- ☐ NAD
- ☐ Discharge
  - ☐ blood ☐ proctitis
  - ☐ ulcers ☐ warts
- ☐ Haemorrhoids
- ☐ Fissures
- ☐ Other:

Proctoscopy:
Any problems on insertion:
☐ Yes ☐ No ☐ N/A

Tests:

Pharyngeal:
- ☐ Gonorrhoea *(C+S swab)*

Urethral:
- ☐ Gonorrhoea *(C+S swab / urine)*
- ☐ Chlamydia *(swab /urine)*

Rectal:
- ☐ Gonorrhoea *(C+S swab)*
- ☐ Chlamydia *(viral swab *)*

** only use if proctitis present: needs Dr examination and inform regular Dr of test*

Health Promotion / Advice / Information
(Couples-counselling, Legal, Counselling for risk reduction strategies, Regular RPR/STI, Leaflets)

Follow-up: ☐ Office appointment ☐ Phone appointment *(book nurses appt)* _____ ☐ Other: _____

Signature: _____ **Printed name:** _____

FOLLOW-UP **Date:** _____ ☐ In office ☐ Phone

Results:

Pharyngeal Gonorrhoea:	☐ Neg	☐ Pos
Urethral Gonorrhoea:	☐ Neg	☐ Pos
Urethral Chlamydia:	☐ Neg	☐ Pos
Rectal Gonorrhoea:	☐ Neg	☐ Pos

Other:

Treatment:
- ☐ Penicillin Allergy
- ☐ Checked for drug interactions

Doctors signature: _____

Printed name: _____

BCCDC
- ☐ Contact Tracing Form completed
- ☐ Referral to BCCDC ☐ N/A

Advice:
Completion:
Adverse effects:
Follow up:

Signature: _____ **Printed name:** _____

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PATIENT CONTACT DETAILS: Cell/landline: _____ ☐ OK to leave message

Letters OK ☐ Yes ☐ No ☐ Address checked

REASON FOR TESTING: (tick all appropriate boxes)

☐ **Routine Screening** Asymptomatic ☐ **Contact:** ☐ Gonorrhoea ☐ Chlamydia ☐ RPR

Symptomatic:

☐ **Urethral:** ☐ Urethral discharge (clear/yellow) ☐ Dysuria ☐ Increased urgency passing urine ☐ Increased frequency urine ☐ Hematuria ☐ Other: _____

☐ **Rectal:** ☐ Discharge ☐ Blood ☐ Mucus ☐ Itching ☐ Pain ☐ Other: _____

☐ **Pharyngeal:** (specify) _____

Other: ☐ Rash ☐ Fever

Last STI Screen and Results:

Last sexual contact	Regular/Casual /Known M/F & Duration	TYPE OF SEX Oral	Anal	Vaginal	Other
		R I	R I	R I	

Total partners: Last 2 months: _____

Last 6 months: _____

Last 12 months: _____

Were any of the above Sex Trade partners:

Any injection Drug use risks: (i.e. drug sharing)

If Yes, what drugs do you currently use?

Other relevant information:

Discussed disclosure: ☐ Yes ☐ No

Risk reduction strategies discussed: ☐ Yes ☐ No