

IMMUNODEFICIENCY CLINIC FEMALE SEXUAL HEALTH SCREEN

Date: _____

PATIENT CONTACT DETAILS: Cell/landline: _____ OK to leave message
 Address checked Letters OK

REASON FOR TESTING: (tick all appropriate boxes)

- | | | |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Routine Screening
Asymptomatic
(per pharyngeal, urethral,
Vaginal, rectal) | <input type="checkbox"/> Contact:
<input type="checkbox"/> Gonorrhoea
<input type="checkbox"/> Chlamydia
<input type="checkbox"/> RPR | <input type="checkbox"/> PAP Smear:
<i>discuss with GP if:</i>
CD4 under 200 + no ARV's |
|---------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|

SYMPTOMATIC:	
General:	<input type="checkbox"/> Fever <input type="checkbox"/> Swollen Lymph nodes
Skin:	<input type="checkbox"/> Rash (palms, feet, etc)
Pharyngeal:	<input type="checkbox"/> Sore throat <input type="checkbox"/> Other:
Urinary:	<input type="checkbox"/> Dysuria <input type="checkbox"/> Increased frequency or urgency <input type="checkbox"/> Hematuria <input type="checkbox"/> Other:
Abdomen:	<input type="checkbox"/> Pelvic pain <input type="checkbox"/> Dyspareunia <input type="checkbox"/> Other:
Genital:	<input type="checkbox"/> Rash <input type="checkbox"/> Lesions <input type="checkbox"/> Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Vulvar itch
Vaginal:	<input type="checkbox"/> Abnormal Vaginal discharge <input type="checkbox"/> Abnormal Vaginal Odour <input type="checkbox"/> Abnormal Vaginal bleeding <input type="checkbox"/> Other:
Rectal:	<input type="checkbox"/> Discharge <input type="checkbox"/> Blood <input type="checkbox"/> Mucus <input type="checkbox"/> Itching <input type="checkbox"/> Pain <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Other:
Other:	

LAST STI SCREEN / RESULTS / TREATMENTS:								
Sexual History:								
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: _____				Other relevant information: Discussed disclosure: <input type="checkbox"/> Yes <input type="checkbox"/> No Risk reduction strategies discussed: <input type="checkbox"/> Yes <input type="checkbox"/> No				
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?								

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OB/GYN HISTORY	
Date of LMP	
Menses usually last X days	
Perimenstrual symptoms are:	<input type="checkbox"/> Absent <input type="checkbox"/> Present:
Breakthrough bleeding outside of menses	<input type="checkbox"/> Absent <input type="checkbox"/> Present:
Obstetrical history	Gravidity: _____ Parity: _____ Abortion: _____ Living: _____
Hysterectomy	<input type="checkbox"/> No <input type="checkbox"/> Yes - if Yes, date:
Contraception	<input type="checkbox"/> Pill <input type="checkbox"/> Nuva Ring <input type="checkbox"/> Patch <input type="checkbox"/> IUD <input type="checkbox"/> Condom <input type="checkbox"/> Other:
PAP in last year	<input type="checkbox"/> No <input type="checkbox"/> Yes - if Yes, - Normal?
Last Clinical Breast Exam	Date:
Last mammogram	Date:

EXAMINATION	
MOUTH	<input type="checkbox"/> NAD <input type="checkbox"/> Candida <input type="checkbox"/> Hairy leukoplakia <input type="checkbox"/> Ulcer <input type="checkbox"/> Pharyngeal erythema <input type="checkbox"/> Pharyngeal exudate
CERVICAL LYMPH NOTES	<input type="checkbox"/> NAD <input type="checkbox"/> Raised and tender <input type="checkbox"/> Other:
PELVIC EXAM	
Inguinal Lymph Nodes	<input type="checkbox"/> NAD <input type="checkbox"/> Raised and tender <input type="checkbox"/> Other:
External Genitalia lesions	<input type="checkbox"/> NAD <input type="checkbox"/> Warts <input type="checkbox"/> Herpes <input type="checkbox"/> Skin tag <input type="checkbox"/> Other:
Bartholin's glands	<input type="checkbox"/> Not palpable <input type="checkbox"/> Palpable <input type="checkbox"/> Other
Vaginal introitus, wall, vault	<input type="checkbox"/> Vaginal mucosa pink, and well rugated <input type="checkbox"/> Other
Vaginal discharge	<input type="checkbox"/> NAD <input type="checkbox"/> Grayish <input type="checkbox"/> White <input type="checkbox"/> Yellow <input type="checkbox"/> Green <input type="checkbox"/> Thick <input type="checkbox"/> Thin <input type="checkbox"/> Other:
Vaginal odour	<input type="checkbox"/> NAD <input type="checkbox"/> Fishy <input type="checkbox"/> Other:
Cervix appears	<input type="checkbox"/> Smooth, with no visible lesions, erosions or scars
Cervical discharge	<input type="checkbox"/> No <input type="checkbox"/> Yes - if Yes:
Cervical friability	<input type="checkbox"/> No <input type="checkbox"/> Yes
Other:	
PERINEUM/ANAL EXAM	<input type="checkbox"/> NAD <input type="checkbox"/> Discharge <input type="checkbox"/> Ulcer <input type="checkbox"/> Wart <input type="checkbox"/> Hemorrhoid <input type="checkbox"/> Fissure <input type="checkbox"/> Other:
BIMANUAL EXAM	
Uterus	<input type="checkbox"/> Midline <input type="checkbox"/> Anteverted <input type="checkbox"/> Retroverted <input type="checkbox"/> Normal size and shape <input type="checkbox"/> Mobile <input type="checkbox"/> No masses <input type="checkbox"/> Non-tender <input type="checkbox"/> Other:
Adnexa	<input type="checkbox"/> Without masses or tenderness bilaterally <input type="checkbox"/> Not felt <input type="checkbox"/> Other
Cervix and Fornices	<input type="checkbox"/> Midline <input type="checkbox"/> Smooth <input type="checkbox"/> No Cervical Motion Tenderness <input type="checkbox"/> Other
Rectovaginal wall	<input type="checkbox"/> Normal sphincter tone <input type="checkbox"/> No masses, nodularity or tenderness <input type="checkbox"/> No occult blood <input type="checkbox"/> Other:



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TESTS / SPECIMENS TAKEN			
Pharyngeal: <input type="checkbox"/> Gonorrhoea (<i>C+S swab</i>) Rectal: <input type="checkbox"/> Gonorrhoea (<i>C+S swab</i>)	Cervical: <input type="checkbox"/> PAP smear <input type="checkbox"/> Gonorrhoea (<i>C+S swab/urine</i>) <input type="checkbox"/> Chlamydia (<i>swab/urine</i>)	Vaginal: <input type="checkbox"/> BV, Yeast, Trich (<i>swab</i>) <input type="checkbox"/> KOH whiff test <input type="checkbox"/> Vaginal PH	Blood: <input type="checkbox"/> Syphilis RPR <input type="checkbox"/> HCV ab Other: _____
Health Promotion / Advice / Information <i>(Couples-counselling, Legal, Counselling for risk reduction strategies, Regular RPR /STI, Leaflets)</i>			

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

Signature: _____ **Printed name:** _____

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

Results: Pharyngeal Gonorrhoea: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Cervical Gonorrhoea: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Cervical Chlamydia: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Rectal Gonorrhoea: <input type="checkbox"/> Neg <input type="checkbox"/> Pos BV / Trichomonas: <input type="checkbox"/> Neg <input type="checkbox"/> Pos Other: _____	Treatment: <input type="checkbox"/> Penicillin Allergy <input type="checkbox"/> Checked for drug interactions Doctors signature: _____ Printed name: _____
BCCDC <input type="checkbox"/> Contact Tracing Form completed <input type="checkbox"/> Referral to BCCDC <input type="checkbox"/> N/A	Advice: Completion: Adverse effects: Follow up:

Signature: _____ **Printed name:** _____

