Sexually Transmitted Infections
Form 2808

N.C. Department of Health and Human Services
Division of Public Health *updated August 2025*

1.Last Name	First Name	MI

2. Patient ID: | 3. Date of Birth:

4. Race: □ White □ Asian □ Native Hawaiian / Other Pacific Islander
□ Black / African American □ American Indian / Alaskan Native □ Other

Ethnicity: Hispanic Origin? □ Yes □ No

5. Current Gender Identity: _____
Have client list preferred gender

6. County of Residence:

7a. Allergies:

7b. Medications:

DATE OF VISIT:_____

8a. **Reason(s) for Visit** (check all that apply)
□ STD Screen (Asymptomatic)
□ Symptomatic
□ Positive Test for _____
□ Referred by _____
□ Contact to person treated for _____
□ Exposed to symptomatic partner
□ Other:

8b. **Contact(s) verified by:** (check at least one)
□ Partner notification card for _____
□ Referral source: _____
□ NCEDSS event ID
□ Verbalization of partner/contact
□ Medical Record of partner/contact

8c. **Symptoms**

Present	Absent	Symptom
□	□	Itch
□	□	Irritation
□	□	Pain
□	□	Discharge
□	□	Dysuria
□	□	Ulcer/Lesion
□	□	Rash

Symptom Parameters
Specify location, quality, severity, duration, frequency, and associated symptoms, if applicable. Document what the client did to relieve the symptoms and the effectiveness of that action(s).

9a. **Prior STD/STI & Date Dx:**
□ Bacterial Vaginosis _____
□ Chlamydia _____
□ Gonorrhea _____
□ Genital Warts_____
□ HIV date of dx _____
state/country of dx_____
□ Oral Herpes_____
□ Genital Herpes_____
□ MPC _____
□ NGU _____
□ PID _____
□ Syphilis date of dx_____
state/country of dx_____
titer result:_____
county where treated:_____
□ Trichomoniasis_____
□ Yeast_____
□ None
□ Other_____
_____
_____
_____
_____

9b. **Vaccines & Testing:**
Hep A Vaccine
□ no □ yes □ unknown
#injections:_____
Last injection date:_____

Hep B Vaccine
□ no □ yes □ unknown
#injections:_____
Last injection date:_____

Twinrix Vaccine
□ no □ yes □ unknown
#injections:_____
Last injection date:_____

Tdap Vaccine
□ no □ yes □ unknown
#injections:_____
Last injection date:_____

HPV Vaccine
□ no □ yes □ unknown
#injections:_____
Last injection date:_____

Prior HIV Test
□ no □ yes □ unknown
Last test date:_____

HBV Status
□ unknown □ acute □ chronic
Date Dx:_____

HCV Status
□ unknown □ acute □ chronic
Date Dx:_____

10a. **Sexual Risk Assessment**

Sexual partners (last 60 days):
with male genitalia:_____
with female genitalia:_____
Date of last sexual encounter:
_____

Sites of exposure (last 60 days):
□ Mouth □ Penis □ Vagina □ Anus □ None

In the last 2 weeks:
Total # sexual encounters:_____
with condom use:_____

10b. **Additional Exposure History:** "When was the last time you…"

Had sex with a person who has the same genitalia as you?	Date:_____	□ Never
Had sex with a bisexual male	Date:_____	□ Never
Had sex with a person living with HIV?	Date:_____	□ Never
Had sex with a person who uses injectable drugs?	Date:_____	□ Never
Shared needles or other works for drug use?	Date:_____	□ Never
Exchanged sex for anything (money, drugs, food, shelter)?	Date:_____	□ Never

10c. **Do you currently use:**

Alcohol: □ no □ yes
Frequency/amount_____

Non-prescribed, injectable substances
□ no □ yes Last injection:_____

Non-injectable substances that alter your mental status:
□ no □ yes Last used:_____ List substance(s):_____

11. **For Women**

LMP: _____/_____/_____
□ regular □ irregular
frequency:_____
Are you pregnant?
□ no □ yes □ unknown
Are you breastfeeding?
□ no □ yes
Last Cervical Screening: (Pap or HPV): _____
□ normal □ abnormal
Douche: □ no □ yes
frequency:_____
last use:_____

Contraception:
□ none
□ emergency contraception
□ oral contraceptive pill
□ injectable – last given:_____
□ implant – inserted:_____
□ IUD – inserted:_____
□ tubal ligation – date:_____
□ condoms
□ hysterectomy – date:_____
□ diaphragm
□ other – list:_____

12. **Comments:**

Signature/Title of Interviewer:_____ **Interpreter (if used):**_____

Signature of provider, if provider is not the interviewer:_____
signing indicates this form was reviewed by provider

Insert Patient/Client Label Here

Document location of abnormal findings

13. Physical Examination Vital Signs, if clinically indicated:
Temp:_____B/P:_____Pulse:_____Resp:_____Weight:_____

□ **Oropharynx**: no lesions; no erythema; no tonsillar exudate □ abnormal:	□ **Penis**: no lesions; no discharge □ abnormal:	**Description of discharge (if present):**	
		Female Clients	**Male Clients**
□ **Scalp, brows, eyes, lashes:** no nits; no hair loss; no eye redness or exudate □ abnormal:	□ **Scrotum**: no tenderness; no nodules; no lesions □ abnormal:	**Amount:** □ small □ moderate □ large **Odor** (with or without KOH) □ yes □ no	**Amount:** □ small □ moderate □ large
□ **Cervical/supraclavicular/axillary/epi-trochlear nodes:** no adenopathy □ abnormal:	□ **Vulva**: no lesions/rashes; no lice/nits □ abnormal:	**pH:** □ >4.5 □ ≤4.5	
□ **Skin:** clear; no lesions/rashes □ abnormal:	□ **Vagina**: no lesions; no erythema; no discharge □ abnormal:	**Adheres to vaginal wall:** □ yes □ no	**Color** (check all that apply): □ clear □ yellow □ green □ color of discharge matches white swab □ other (specify)
□ **Abdomen:** no tenderness to palpation; no rebound tenderness □ abnormal:	□ **Cervix**: no lesions; no erythema; no discharge; no CMT □ abnormal:	**Color** (check all that apply): □ clear □ yellow □ gray/off white □ green □ bright red □ dark red □ color of discharge matches the white swab	
□ **Inguinal nodes**: no adenopathy □ abnormal:	□ **Uterus**: no enlargement; no tenderness □ abnormal:		
□ **Pubic area**: no lesions/rashes; no lice/nits □ abnormal:	□ **Anus**: no lesions; no discharge □ abnormal:		
Additional findings:			

14. Laboratory

□ Gonorrhea Test: □ NAAT □ culture
□ Cervical □ Urethral □ Urine
□ Rectal □ Pharyngeal □ Vaginal
□ Urethral Gram Stain:
□ No GNID found □ ≥ 2 WBC, no GND found □ Extracellular GND only □ GNID found
□ Herpes Test: □ Culture □ Serology
□ HIV
□ Chlamydia Test: □ NAAT □ Other
□ Cervical □ Urethral □ Urine
□ Rectal □ Pharyngeal □ Vaginal
□ Syphilis Serology
□ Stat RPR: □ reactive □ nonreactive
□ Darkfield: □ found □ not found
□ Wet Prep: □ clue cells □ yeast □ KOH+ □ trich □ WBCs_____
□ Cervical Cancer: □ HPV □ Pap smear
□ Pregnancy Test: □ positive □ negative
□ Other: _____

15. Clinical Impressions / Diagnosis

□ Bacterial vaginosis
□ Candidal infection
□ Cervicitis / MPC
□ Chlamydia
□ Epididymitis
□ Gonorrhea
□ Herpes: □ 1st episode □ Recurrent
□ HIV
□ HPV / Genital warts
□ NGU
□ Pediculosis pubis
□ PID
□ Scabies
□ Syphilis: □ Primary □ Secondary □ unknown duration □ Early latent □ Late latent
□ Tinea cruris
□ Trichomoniasis
□ Contact to: _____
□ STD Screening (asymptomatic), lab tests pending
□ Other:_____

16. Treatment / Therapy

□ None
□ Reviewed client's allergy history
□ Reviewed client's pregnancy status
□ Reviewed client's breastfeeding status
□ Medication instructions provided according to policy and/or standing order
□ Restrictions for alcohol consumption given:
Specify:_____
□ Azithromycin PO_____
□ Benzathine penicillin G 2.4 MU IM
□ single dose
□ 3 doses (each at 1-week interval)
□ Ceftriaxone IM_____
□ Doxycycline PO_____
□ Metronidazole PO_____
□ Acyclovir PO_____
□ Cryotherapy_____
□ TCA_____
□ OTC fungal/yeast _____
□ OTC pediculosis pubis_____
□ Other_____

x_____
Name/Title of person administering or dispensing
Treatment Date:_____

17. Instructions/Counseling

□ Abstain from sex for ____ days and until partner(s) is treated
□ Use condoms or other barrier methods for risk reduction
□ RTC if symptoms persist/increase
□ Partner notification □ cards given
□ Printed risk reduction and infection information
□ Reviewed services provided and tests performed
□ HIV Control Measures reviewed, and post-test counseling done (if applicable)
□ Referrals:

18. Follow-up for Test Results:

□ Clinic will call with results only if a test result is abnormal or requires re-testing
□ Results available through patient portal
□ Client will call for results
□ Unique password to obtain results by phone: _____
□ Preferred phone #s to contact client about results or follow-up:_____
□ Clinic may leave message at preferred # □ Yes □ No
□ Other:

NOTES:

Signature/Title of Examiner_____

Co-Signature (if needed):_____ ERRN Time: _____ minutes = _____ units (T1002)