CONFIDENTIAL STD MORBIDITY REPORT FORM

Houston Health Department
ATTN: Bureau of Epidemiology – STD Surveillance 4th floor
8000 North Stadium Drive Houston, Texas 77054
Tel: (832)393-5080 Fax: (832)393-5233

Instructions: Please complete all fields on this form. If information is not available, write "NA." Fax completed forms to 832-393-5233.

Reported by: **Facility/Clinic**: **Phone Number**: **Date**:

PATIENT DEMOGRAPHIC DATA

Last Name: **First Name, MI**:

DOB: **Social Security #**: - - **Sex**: □M □ F

Race: □ White □ Black/African American □ Asian/Pacific Islander □ Other □ Unknown **Hispanic**: □Y □ N

Address: **Home Phone**: ( ) --

City, State Zip code: **Other Phone**: ( ) --

Emergency Contact Name: **Contact Phone**: ( ) --

Marital Status: □Single □Married □Divorced □Widowed □Unknown

Pregnancy Status: □N/A □No □Yes (Expected delivery date___/___/___) □ Unknown(Last menstrual date___/___/___)

Reason for Test: □ Routine screening □ Prenatal Screening □ Immigration Screening □ Screening due to partner's treatment/diagnosis
□ Signs and Symptoms □ Employment screening □ Other reason:_____

DISEASE DATA

Check Reportable Disease(s):
□ Syphilis** □ Gonorrhea □ Chlamydia □ Chancroid

Patient's chief complaint(s):_____
Describe any signs and symptoms:_____
Symptom Onset Date:_____**Duration of symptoms**:_____**Provider diagnosis**:_____
Provider follow-up appointment date:_____
Referred to provider name:_____**Provider phone**:_____
Syphilis only:
Stage of syphilis: □Primary □Secondary □Early Latent □Late Latent □Other:_____
Last negative RPR test date:_____**Other previous syphilis serology results**:

LABORATORY DATA

Was patient tested for syphilis? □ Yes □ No
Test date:___/___/___Reporting lab:_____
□ **RPR Titer**: □ Reactive – Titer 1:_____□ Non-reactive
□ **VDRL Titer**: □ Reactive – Titer 1:_____ □ Non-reactive

□ **TP-PA**: □ Reactive □ Non-reactive
□ **FTA-ABS**: □ Reactive □ Non-reactive
□ **MHA-TP**: □ Reactive □ Non-reactive
□ **EIA (IgG/IgM)**: □ Reactive □ Non-reactive
Other test results:
_____
_____

Was patient tested for HIV? □ Yes □ No
□ IFA □ W. Blot □ Rapid □ EIA □ Ag/Ab □Ab DIF Date:___/___/___□ Pos □ Neg
□ IFA □ W. Blot □ Rapid □ EIA □ Ag/Ab □Ab DIF Date:___/___/___□ Pos □ Neg
Reporting lab:_____

Was patient tested for Gonorrhea/Chlamydia? □ Yes □ No
Chlamydia Test Date:___/___/___□ Pos □ Neg
Specimen source: □Urine □Cervix □Urethra □Pharynx □Rectum □Unknown
Gonorrhea Test Date:___/___/___□ Pos □ Neg
Specimen source: □Urine □Cervix □Urethra □Pharynx □Rectum □Unknown
Reporting lab:_____

Has patient been notified of test results? □Y □ N If yes, date of notification:_____**and for which lab(s):**_____
Please share with your patient that he/she will be contacted by the health department for counseling and public health follow-up.

TREATMENT INFORMATION

Was patient treated? □Yes □No **Treatment date(s)**:_____

Prior History of Treatment: □Yes □No □ Unknown Date of Previous Treatment___/___/___
Method of Prior Treatment_____

Current medication(s) prescribed:
□ Benzathine penicillin G 2.4 MU IM x 1
□ Benzathine penicillin G 2.4 MU IM x 3
□ Doxycycline 100mg PO BID for 7d
□ Doxycycline 100mg PO BID for 10d
□ Doxycycline 100mg PO BID for 14d
□ Doxycycline 100mg PO BID for 28d
□ Amoxicillin 500mg PO TID x 7d
□ Azithromycin 1 gm PO x 1
□ Ceftriaxone 125mg IM x 1
□ Ceftriaxone 250mg IM x 1
□ Erythromycin base 500mg PO TID 7d
□ Erythromycin base 500mg PO QID 7d
□ Cefixime 400mg PO x 1
□ Other not listed, please list:
_____
_____
_____
_____