NORTH Dakota | Health & Human Services
Be Legendary.

CHLAMYDIA/GONORRHEA PATIENT INTERVIEW

NORTH DAKOTA DEPARTMENT OF HEALTH
DIVISION OF DISEASE CONTROL
SFN 61113 (02/2021)

You are being tested and/or treated for a sexually transmitted infection (STI). It is important for your health that your sexual partners are also treated for this infection. Sex partners and people infected with STIs may not know they are infected because many time people do not have symptoms, or only mild symptoms. It is important that **ALL** of your current and former sex partners are treated to prevent you from becoming reinfected, and to protect others from being infected.

Your name will never be used if the North Dakota Department of Health or your healthcare provider refers your partners in for testing and treatment. Your information is strictly confidential. Please list all of the people you have had sex with in the last 3 months. If you have not had sex in the last 3 months, list your last sex partner. Please provide as much information as you can.

It is essential you wait seven (7) days after you and your partner(s) have been treated before you have sex again. Do not have sex again with your current partner until they have been treated.

Patient Information:

First Name:	*Last Name:*	*Date of Birth:*	
Street Address:	*City:*	*State:*	*ZIP Code:*
Telephone Number:	*Assigned sex at birth:* ☐ Male ☐ Female		
Current Gender Identity: ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Transgender Unspecified ☐ Another Gender ☐ Declined to Answer			
Race: ☐ American Indian/Alaskan Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Pacific Islander ☐ White ☐ Refused		*Ethnicity:* ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Refused	
Pregnancy Status: ☐ Not Pregnant ☐ Pregnant ☐ N/A		If Pregnant, Due Date:	

Risk History Information:

Do you have a history of previous STI infections?	☐ Yes ☐ No		
Are you a resident/staff of correctional facility?	☐ Yes ☐ No		
Have you ever used intravenous/injection drugs?	☐ Yes ☐ No		
Have you ever used non-injection drugs?	☐ Yes ☐ No		
Have you ever had sex while high/intoxicated?	☐ Yes ☐ No		
Have you ever had sex with an injection drug user?	☐ Yes ☐ No		
Have you ever traded sex for drugs or money?	☐ Yes ☐ No		
Have you ever had sex with an anonymous sex partner?	☐ Yes ☐ No		
Have you ever met sexual partners on the internet?	☐ Yes ☐ No		
Total number of sex partners in the last 12 months:			
*Number of **Female** Partners*			
*Number of **Male** Partners*			
*Number of **Transgender** Partners*			
What types of sex have you had?	☐ Vaginal	☐ Oral, receive ☐ Oral, unspecified ☐ Oral, perform	☐ Anal, top ☐ Anal, bottom ☐ Anal, unspecified
How frequently do you use condoms during sex?	☐ Always (100%) ☐ Most of the time (75%)	☐ Half the time (50%) ☐ Not that Often (25%)	☐ Never (0%)

Patient Initials: _____

Sex Partner History*

*Please list all information on any sexual partners within the last 60 days or the last sexual partner if the last time you had sex was more than 60 days ago. *Please see page 4 for additional space if needed.*

Partner Name:		*Date of Birth or Approximate Age:*	*Gender:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I would like my provider/health department to refer in my partner. (*The provider/health department will never use your name or other identifying information when referring in your partner(s) for treatment)* ☐ I have no way of contacting this partner.			*Is your partner pregnant?* ☐ Yes ☐ No
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	
Partner Specimen Collection Date:		*Partner Treatment Date:*	
Partner Results:		*Was partner treated via EPT?* ☐ Yes ☐ No	

Partner Name:		*Date of Birth or Approximate Age:*	*Gender:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I would like my provider/health department to refer in my partner. (*The provider/health department will never use your name or other identifying information when referring in your partner(s) for treatment)* ☐ I have no way of contacting this partner.			*Is your partner pregnant?* ☐ Yes ☐ No
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	
Partner Specimen Collection Date:		*Partner Treatment Date:*	
Partner Results:		*Was partner treated via EPT?* ☐ Yes ☐ No	

Patient Initials: _____

This section is to be completed by the healthcare provider.

Provider Information

Reportable Condition: ☐ Chlamydia ☐ Gonorrhea	*Specimen Collection Date:*
Diagnosing HealthCare Provider:	
Facility:	*Telephone Number:*
Positive Specimen Source(s): ☐ Urine ☐ Cervix ☐ Rectum ☐ Pharyngeal	*Negative Specimen Source(s):* ☐ Urine ☐ Cervix ☐ Rectum ☐ Pharyngeal
Case Also Tested for: ☐ Chlamydia ☐ Gonorrhea	*Testing Laboratory:*

Treatment Information

Was treatment given for this infection? ☐ Yes ☐ No	*Treatment Date:*
Chlamydia: ☐ 1g Azithromycin ☐ 100mg Doxycycline BID x 7 days	***Gonorrhea:*** ☐ 500mg IM Ceftriaxone ☐ 1g IM Ceftriaxone (if patient is >150kg (330lbs) ☐ 500mg Ceftriaxone & 100mg Doxycycline BID x 7 Days
PID: ☐ 250mg IM Ceftriaxone & 100mg Doxycycline BID x 14 days ☐ 2g IM Cefoxitin & 1g Oral Probenecid & 100mg Doxycycline BID x 14 days ☐ Other Parenteral Third-generation Cephalosporin & 100mg Doxycycline BID x 14 days	☐ 500 mg BID Metronidazole BID x 14 days (not required)
Alternate therapy?	
If not observed, what pharmacy was prescription sent to?	
Was follow up appointment made in 3 months to have a test for re-infection? ☐ Yes ☐ No	

Clinical History

Reason Test Conducted: ☐ Infection ☐ Screen ☐ Partner Referral		
Were symptoms noted? ☐ Yes ☐ No	*If Yes, onset date:*	*Please note symptoms:*
Was PID diagnosed? ☐ Yes ☐ No		
Was case tested for HIV? ☐ Yes ☐ No	*If Yes, Collection Date:*	*Result*: ☐ Positive ☐ Negative
Was case tested for Syphilis? ☐ Yes ☐ No	*If Yes, Collection Date:*	*Result*: ☐ Positive ☐ Negative
Was follow up appointment made in 3 months to have a test for reinfection? ☐ Yes ☐ No		

Please Fax Completed Forms to 701.328.0355. Questions Contact NDDoH at 701.328.2378.

Patient Initials: _____

Additional Sex Partner History

Partner Name:		*Date of Birth or Approximate Age:*	*Gender:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I would like my provider/health department to refer in my partner. (*The provider/health department will never use your name or other identifying information when referring in your partner(s) for treatment)* ☐ I have no way of contacting this partner.			*Is your partner pregnant?* ☐ Yes ☐ No
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	
Partner Specimen Collection Date:		*Partner Treatment Date:*	
Partner Results:		*Was partner treated via EPT?* ☐ Yes ☐ No	

Partner Name:		*Date of Birth or Approximate Age:*	*Gender:* ☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Another Gender
Address:	*City:*	*State:*	*Telephone Number:*
Email Address/Phone Apps/Social Media Identifier (ex. Facebook ID):			
Date of First Exposure:		*Frequency of Exposure:*	
Date of Last Exposure:		*Note for Exposure Dates: Include approximate dates if exact date unknown.*	
Any notes about this person if name and location are unknown:			
Choose one of the following: ☐ This partner is here with me and is being treated today. ☐ I will bring my current partner with me to the clinic. ☐ I will contact this partner and refer them to the clinic. ☐ I would like my provider/health department to refer in my partner. (*The provider/health department will never use your name or other identifying information when referring in your partner(s) for treatment)* ☐ I have no way of contacting this partner.			*Is your partner pregnant?* ☐ Yes ☐ No
For Provider Use:			
Was this partner tested? ☐ Yes ☐ No		*Partner Treatment Type:*	
Partner Specimen Collection Date:		*Partner Treatment Date:*	
Partner Results:		*Was partner treated via EPT?* ☐ Yes ☐ No	