STD CONFIDENTIAL MORBIDITY REPORT

✓ DISEASE: ☐ **CHLAMYDIA** ☐ **GONORRHEA** ☐ **SYPHILIS/Stage:**

Patient's Last Name

First Name/Middle Name (or Initial)

Social Security Number

Birth Date (MM / DD / YY) Age (Years)

Address: (Number, Street)

City/Town State Zip Code

Area Code Home Telephone

Gender: ☐ M ☐ F ☐ M to F ☐ F to M ☐ Other:

Area Code Work Telephone

Pregnant? ☐ Y ☐ N ☐ UNK

Est. Delivery Date (MM / DD / YY)

Area Code Cell Telephone

Email

Ethnicity (✓ one)
- ☐ Hispanic/Latino
- ☐ Non-Hispanic/Non-Latino

Race (✓ one)
- ☐ African-American/Black
- ☐ Asian/Pacific Islander (✓ one)
  - ☐ Asian-Indian
  - ☐ Cambodian
  - ☐ Chinese
  - ☐ Filipino
  - ☐ Guamanian
  - ☐ Hawaiian
  - ☐ Japanese
  - ☐ Korean
  - ☐ Laotian
  - ☐ Samoan
  - ☐ Vietnamese
  - ☐ Other:
- ☐ Native American
- ☐ Caucasian/White
- ☐ Other:

Language Spoken:

DATE OF ONSET (Month / Day / Year)

DATE DIAGNOSED (Month / Day / Year)

SPECIMEN COLLECTED
☐ Not tested (Month / Day / Year)

Reporting Health Care Provider

Reporting Health Care Facility

Address

City State Zip Code

Telephone: Fax:

Submitted by: Submit Date:

REPORT TO

COUNTY OF SANTA CRUZ
Health Services Agency
1060 Emeline Ave
Santa Cruz, CA 95060
Phone: (831) 454-4114
Fax: (831) 454-5049

STD DIAGNOSIS

Syphilis
- ☐ Primary (lesion present)
- ☐ Secondary
- ☐ Early latent < 1 year
- ☐ Neurosyphilis
- ☐ Late Latent > 1 year
- ☐ Late (tertiary)
- ☐ Congenital

Syphilis Test Results
- ☐ RPR Titer:____
- ☐ VDRL Titer:____
- ☐ FTA/TPPA: ☐ Pos ☐ Neg
- ☐ CSF-VDR: ☐ Pos ☐ Neg
- ☐ Other

Gonorrhea
- ☐ Urine
- ☐ Urethral/Cervical
- ☐ PID/Gonorrhea
- ☐ Rectal
- ☐ Pharyngeal

Chlamydia
- ☐ Urine
- ☐ Urethral/Cervical
- ☐ PID/Chlamydia
- ☐ Rectal
- ☐

- ☐ **PID**
- ☐ **Chancroid**
- ☐

STD TREATMENT INFORMATION

☐ **Treated:** **Drugs:**
- ☐ Treated in office w/:
- ☐ Given prescription for: **Dosage:**

☐ **Treated Presumptively**

Date Treatment Given:

☐ **Will treat**

☐ **Untreated**

☐ **Unable to contact patient**

GENDER OF SEX PARTNERS: (check all that apply)
- ☐ Male
- ☐ Female
- ☐ Unknown
- ☐ Male to Female Transgender
- ☐ Female to Male Transgender
- ☐ Other:

PARTNER INFORMATION

Partner's Name Age

Address City State Zip

Home Phone Work Phone

Treated:
- ☐ Treated in office w/:
- ☐ Given prescription for:
- ☐ Patient delivered partner tx:

Drugs:

Dosage:

Date Treatments Given:

☐ **Will Treat**

☐ **Untreated**

NOTES:

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