

# STD CONFIDENTIAL MORBIDITY REPORT

Rev. 12/09

**DISEASE:**  
  **CHLAMYDIA**  
  **GONORRHEA**  
  **PID**  
  **NGU**  
  **SYPHILIS-Stage:** \_\_\_\_\_

Patient's Last Name <input style="width: 100%;" type="text"/>		Social Security Number <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/> <input style="width: 20%;" type="text"/>		<b>Ethnicity (✓ one)</b>	
First Name/Middle Name (or Initial) <input style="width: 100%;" type="text"/>		Birth Date MM <input style="width: 20px;" type="text"/> DD <input style="width: 20px;" type="text"/> YY <input style="width: 20px;" type="text"/>		<input type="checkbox"/> Hispanic/Latino <input type="checkbox"/> Non-Hispanic/Non-Latino	
Address: (Number, Street) <input style="width: 100%;" type="text"/>		City/Town <input style="width: 100%;" type="text"/>		<b>Race (✓ one)</b>	
State <input style="width: 100%;" type="text"/>		Zip Code <input style="width: 100%;" type="text"/>		<input type="checkbox"/> African-American/Black <input type="checkbox"/> Asian/Pacific Islander (✓ one)	
Area Code <input style="width: 50px;" type="text"/>	Home Telephone <input style="width: 150px;" type="text"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	Pregnant? Y <input type="checkbox"/> N <input type="checkbox"/> UNK <input type="checkbox"/>	<input type="checkbox"/> Asian-Indian <input type="checkbox"/> Japanese <input type="checkbox"/> Cambodian <input type="checkbox"/> Korean <input type="checkbox"/> Chinese <input type="checkbox"/> Laotian <input type="checkbox"/> Filipino <input type="checkbox"/> Samoan <input type="checkbox"/> Guamanian <input type="checkbox"/> Vietnamese <input type="checkbox"/> Hawaiian <input type="checkbox"/> Other:	
Area Code <input style="width: 50px;" type="text"/>	Work Telephone <input style="width: 150px;" type="text"/>	Area code <input style="width: 50px;" type="text"/>	Cell Phone <input style="width: 150px;" type="text"/>	<input type="checkbox"/> Native American <input type="checkbox"/> Caucasian/White <input type="checkbox"/> Other:	
<b>Language Spoken:</b>					

<p><b>DATE OF ONSET</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Month</th><th>Day</th><th>Year</th></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> </table> <p><b>DATE DIAGNOSED</b></p> <table border="1" style="width: 100%; border-collapse: collapse;"> <tr><th>Month</th><th>Day</th><th>Year</th></tr> <tr><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td><td style="width: 30px; height: 20px;"></td></tr> </table>	Month	Day	Year				Month	Day	Year				Reporting Health Care Provider <input style="width: 100%;" type="text"/>		<p><b>REPORT TO</b></p> <p>County of Santa Cruz Health Services Agency Communicable Disease Unit 1060 Emeline Ave., Bldg F Santa Cruz, CA 95060 Phone: (831) 454-4114 Fax: (831) 454-5049</p>
	Month	Day	Year												
	Month	Day	Year												
	Reporting Health Care Facility <input style="width: 100%;" type="text"/>														
Address <input style="width: 100%;" type="text"/>															
City <input style="width: 100%;" type="text"/>	State <input style="width: 100%;" type="text"/>	Zip Code <input style="width: 100%;" type="text"/>													
Telephone: <input style="width: 100%;" type="text"/>	Fax: <input style="width: 100%;" type="text"/>														
Submitted by: <input style="width: 100%;" type="text"/>	Submit Date: MM <input style="width: 20px;" type="text"/> DD <input style="width: 20px;" type="text"/> YY <input style="width: 20px;" type="text"/>														

## STD DIAGNOSIS

<p><b>Syphilis</b></p> <input type="checkbox"/> Primary (lesion present) <input type="checkbox"/> Secondary <input type="checkbox"/> Early latent < 1 year <input type="checkbox"/> Latent (unk duration) <input type="checkbox"/> Neurosyphilis	<input type="checkbox"/> Late Latent > 1 year <input type="checkbox"/> Late (tertiary) <input type="checkbox"/> Congenital	<p><b>Syphilis Test Results</b></p> <input type="checkbox"/> RPR Titer: _____ <input type="checkbox"/> VDRL Titer: _____ <input type="checkbox"/> FTA/TPPA: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> CSF-VDRL: <input type="checkbox"/> Pos <input type="checkbox"/> Neg <input type="checkbox"/> Other	<p><b>Gonorrhea</b></p> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID/Gonorrhea <input type="checkbox"/> Wet & Prep Results <input type="checkbox"/> Other: _____	<p><b>Chlamydia</b></p> <input type="checkbox"/> Urethral/Cervical <input type="checkbox"/> PID/Chlamydia <input type="checkbox"/> Other: _____	<input type="checkbox"/> <b>PID</b> <input type="checkbox"/> <b>Chancroid</b> <input type="checkbox"/> <b>Non-Gonococcal Urethritis</b>
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<p><b>STD TREATMENT INFORMATION</b></p> <p><input type="checkbox"/> <b>Treated:</b> (Drugs, Dosage, Route)  <input type="checkbox"/> Treated in office w/:  <input type="checkbox"/> Given prescription for:</p> <p>Date Treatment Given MM <input style="width: 20px;" type="text"/> DD <input style="width: 20px;" type="text"/> YY <input style="width: 20px;" type="text"/></p> <p><input type="checkbox"/> Will treat  <input type="checkbox"/> Untreated  <input type="checkbox"/> Unable to contact patient</p>	<p><b>PARTNER INFORMATION</b></p> <p>Partner's Name <input style="width: 100%;" type="text"/> Age <input style="width: 50px;" type="text"/></p> <p>Address <input style="width: 100%;" type="text"/> City <input style="width: 100px;" type="text"/> State <input style="width: 100px;" type="text"/> Zip <input style="width: 100px;" type="text"/></p> <p>Home Phone <input style="width: 100%;" type="text"/> Work Phone <input style="width: 100%;" type="text"/></p> <p><b>Tested:</b>  <input type="checkbox"/> CT  <input type="checkbox"/> GC  <input type="checkbox"/> RPR  <input type="checkbox"/> HIV  <input type="checkbox"/> Not tested</p> <p><input type="checkbox"/> <b>Treated:</b> (Drugs, Dosage, Route)  <input type="checkbox"/> Treated in office w/:  <input type="checkbox"/> Given prescription for:  <input type="checkbox"/> Patient delivered partner tx: _____</p> <p>Date Treatments Given MM <input style="width: 20px;" type="text"/> DD <input style="width: 20px;" type="text"/> YY <input style="width: 20px;" type="text"/></p> <p><input type="checkbox"/> Will Treat  <input type="checkbox"/> Untreated</p>
<p><b>NOTES:</b></p> <input style="width: 100%; height: 100px;" type="text"/>	