STD CONFIDENTIAL MORBIDITY REPORT

Rev. 12/09

✓ DISEASE: ☐ **CHLAMYDIA** ☐ **GONORRHEA** ☐ **PID** ☐ **NGU** ☐ **SYPHILIS-Stage:** _____

Patient's Last Name | Social Security Number

First Name/Middle Name (or Initial) | Birth Date (MM DD YY) | Age (Years)

Address: (Number, Street)

City/Town | State | Zip Code

Area Code | Home Telephone | Gender (M ☐ F ☐) | Pregnant? (Y ☐ N ☐ UNK ☐) | Est. Delivery Date (MM DD YY)

Area Code | Work Telephone | Area code | Cell Phone

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

Reporting Health Care Provider

Reporting Health Care Facility

Address

City | State | Zip Code

Telephone: | Fax:

Submitted by: | Submit Date: (MM DD YY)

REPORT TO

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

STD DIAGNOSIS

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

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

Gonorrhea
- ☐ Urethral/Cervical
- ☐ PID/Gonorrhea
- ☐ Wet & Prep Results
- ☐ Other:____

Chlamydia
- ☐ Urethral/Cervical
- ☐ PID/Chlamydia
- ☐ Other:____

- ☐ **PID**
- ☐ **Chancroid**
- ☐ **Non-Gonococcal Urethritis**

STD TREATMENT INFORMATION

☐ **Treated:** **(Drugs, Dosage, Route)**
- ☐ Treated in office w/:
- ☐ Given prescription for:

Date Treatment Given (MM DD YY)

☐ **Will treat**
☐ **Untreated**
☐ **Unable to contact patient**

PARTNER INFORMATION

Partner's Name | Age

Address | City | State | Zip

Home Phone | Work Phone

Tested:
- ☐ CT
- ☐ GC
- ☐ RPR
- ☐ HIV
- ☐ Not tested

☐ **Treated:** **(Drugs, Dosage, Route)**
- ☐ Treated in office w/: _____
- ☐ Given prescription for: _____
- ☐ Patient delivered partner tx: _____

Date Treatments Given (MM DD YY)

☐ **Will Treat**
☐ **Untreated**

NOTES: