Hud/STD-mottagningen
Questions for a new visitor/form for referral

Rev: 2018-11-22

VÄSTRA GÖTALANDSREGIONEN
SÖDRA ÄLVSBORGS SJUKHUS

Name:				
Date of birth:	Year	Month	Day 4 last -	Date of visit

If it's **not OK** to contact you, put an X in the box: **letter**: ☐ **and/or** **telephone**: ☐

Mobile:	**Home phone number**:

For what cause are you here?

To ensure:	☐	Tested positive at: www.klamydia.se	☐
Told by a partner:	☐	Health central:	☐
Letter from partner:	☐	Youth department:	☐
Symptoms:	☐ specify symtoms	At midwives department:	☐

Symptoms…… For how long?……..

Had any prior infections?:

Chlamydia: ☐ Condyloma: ☐ Gonorrhoea: ☐ Herpes: ☐ Syphilis: ☐ Other: ☐

1.	How many partners have you had the last 12 months? ……..					
2.	Do you have a steady/regular partner?	Yes	☐	No	☐	
3.	Does your partner have symptoms?	Yes	☐	No ☐	Don't know	☐
4.	Male/female partners, both?	Male:	☐	and/or	Female:	☐
5.	Any sexual contact with person outside Sweden?	What country? …… Year/when? ……				
6.	Had sexual contact with person unknown to you?	Yes	☐	No	☐	How long ago? ……
7.	Given/got payment for sex?	Yes	☐	No	☐	How long ago? ……
8.	Do you use condoms?	Always	☐	Some-times	☐	Never ☐
9.	Anal sex with casual partner?	Yes	☐	No	☐	
10.	Oral sex with casual partner?	Yes	☐	No	☐	

Are you allergic to any antibiotics? Yes ☐ No ☐ Which .....

Do you use any medicine? Yes ☐ No ☐ Which.....

Do you have any diseases? Yes ☐ No ☐ Which.....

When did you las urinate? Approximately at: ……o'clock

Questions only for for **women**:

Anticonceptions: Yes ☐ No ☐ What kind? ……

Are you pregnant? Yes ☐ No ☐ Don't know ☐

On your period at the moment? Yes ☐ No ☐

First day of last menstruation: ……