

**COLLEGE OF WILLIAM AND MARY
STUDENT HEALTH CENTER
GU Check List - Male**

Name: _____ ID# _____ Date _____

Telephone # _____ Age _____ Drug Allergies _____

Current Medications (including herbals and vitamins) _____

Do you have Diabetes? _____ Hepatitis B vaccination series completed? _____

Regular condom use? _____ History of unprotected intercourse? _____ Dates _____

History of sexually transmitted infection (STI) If yes: Type/Date/Treatment _____

Have you ever had an HIV Test? _____ date/result _____

Have you had sex with men _____ women _____ both _____

Have any of your partners been bisexual _____ used drugs _____ had a history of STI's _____

Have you had more than one partner? _____ Number of partners in the past year _____

Symptoms: Abdominal Pain _____ Discharge from penis _____ Color _____

Itching/sores/bumps on/in: mouth penis scrotum rectal area Length of time present _____

Known exposure to any STI /type _____

Length of time since you last urinated _____

Please be aware we are required to report certain infections to the Health Dept. **if** testing is **positive**.

Do not write below this line (for Health Center use only)

S: _____

O: T _____ B/P _____ P _____ R _____

Mouth: _____

Penis: _____

Scrotum: _____

Rectum: _____

A: _____

P: Tests Done: U/A Acetic acid **Chlamydia GC HIV RPR HSV Culture**
Hep. B Serology other _____

Treatment: _____

Patient instruction: Safer sex Hepatitis A and B HIV

Positive: **Chlamydia GC HIV RPR** reported to PHD _____ (initials) _____ (date)

Nurse _____ Clinician MD NP PA