STI Screen and Consent

Do you have any medication allergies? None known ☐ Yes (list) _____

Date of Last Sex:_____How many partners have you had in the last 2 weeks? _____

Do you have sex with : Men ☐ Women ☐ Both ☐

What type of sexual contact have you had? Vaginal ☐ Oral ☐ Anal ☐

Do you have any of these symptoms in past 3 weeks? Drainage ☐ Discharge ☐

Odor ☐ Blisters ☐ Rash ☐ Pain ☐ Fever ☐ Flu like symptoms ☐

Other_____

Have you ever been treated for a sexually transmitted infection? Yes ☐ No ☐

If so which one? _____ Date of Treatment_____

Name, Last: _____ Name, First: _____ MI: _____

Student ID: 909 _____ DOB: _____ Cell Phone # _____

LOCAL Address: _____ City _____ State _____ Zip _____

RACE	**ETHNICITY**	**Sex**
☐ American Indian/Alaska Native ☐ Asian ☐ Black/African-American ☐ Native Hawaiian/Pacific Islander ☐ White/ Caucasian ☐ Multi-Racial	☐ Hispanic or Latino ☐ Non-Hispanic or Latino	☐ Male ☐ Female
	Pregnant? ☐ Yes ☐ No ☐ N/A **Last LMP** _____	

Please select your preferred means of contact by SHC nurses

☐ CSU Email: _____@columbusstate.edu

☐ Phone (Cell): _____

NOTICE OF PRIVACY PRACTICES PATIENT ACKNOWLEDGEMENT By signing below, I acknowledge that I have received, read and understood the Student Health Center's Notice of Privacy Practices (Privacy Notice). https://healthservices.columbusstate.edu/docs/CSU-Notice-of-Privacy-Practices.pdf We are required to submit diagnosis/treatment of sexually transmitted diseases into **SendSS** (State Electronic Notifiable Disease Surveillance System)

Student Signature: _____ Date: _____

To be completed by Staff RN: Med Allergies: _____ Weight: _____

Nurse Initials: _____Date/Time:_____