Columbus State University Student Health Center – STI Screen and Consent

Date: _____

Last Name: _____ **First Name:** _____

ID # 909_____ **DOB:** _____ **Cell:** _____

LOCAL Address: _____ **City** _____ **State**_____ **Zip** _____

Sex: ☐ **Male** ☐ **Female**

Race: ☐ **American Indian/ Alaska Native** ☐ **Asian** ☐ **Black/ African American** ☐ **Multi-Racial**
☐ **Native Hawaiian/ Pacific Islander** ☐ **White/ Caucasian**

Ethnicity: ☐ **Hispanic or Latino** ☐ **Non-Hispanic or Latino**

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://www.columbusstate.edu/health-services/_docs/CSU-Notice-of-Privacy-Practices.pdf

I understand that the Student Health Center is required to submit diagnosis/treatment of a sexually transmitted diseases into a State Electronic Notifiable Disease Surveillance System.

Student Signature: _____ **Date:** _____

Do you have any medication allergies? ☐ **None Known** ☐ **Yes List:** _____

Date of last sex: _____ **Your sex partners are:** ☐ **Men** ☐ **Women** ☐ **Both**

Are you concerned about a recent sexual encounter that you have had? ☐ **Yes** ☐ **No**

What type of sex have you had? ☐ **Vaginal** ☐ **Oral** ☐ **Anal**

Have you had any of these symptoms in the past 3 weeks? ___ Blisters ___ Discharge ___ Drainage ___Odor
☐ **Pain** ☐ **Fever** ☐ **Flu like symptoms Other:** _____

Have you ever had a Sexually Transmitted Infection? ☐ **Yes** ☐ **No If yes, Date:** _____

Name of infection: _____ **Were you treated?** ☐ **Yes** ☐ **No**

Do you have a history of HIV? ☐ **Yes** ☐ **No**

Please select your preferred means of contact.

CSU Email: _____ **@students.columbusstate.edu**

Cell: _____

To be Completed by Staff RN

Med. Allergies: _____ **Weight:** _____

Date: _____ **Time:** _____ **Nurse Initials:** _____

Revised 07/2025