

GU INFECTION

DATE _____ NAME _____ DOB/Age _____

ALLERGIES _____ LMP _____

S DURATION _____ Dysuria frequency urgency hematuria incomplete emptying fever ABD pain flank pain pelvic pain
nausea/vomiting dyspareunia OTHER _____

VAGINAL/URETHRAL Discharge discomfort puritus bumps sores blisters WET MOUNT _____

O VITALS BP _____ P _____ T _____ Weight _____ Urine PG _____ UA _____

A _____

P _____

RX _____

UC _____ VAG/URETHRAL CULTURE _____ GC/CHLAMYDIA _____ HSV _____ IVP _____

Partner RX _____ Back-up contraceptive _____

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