Place label here OR write TODAY'S DATE _____

PATIENT'S NAME _____

PATIENT # _____

PATIENT'S DOB _____

Partner Information

Name _____ M ☐ F ☐

First sexual encounter: _____

Last sexual encounter: _____

Type of sex: ☐ Vaginal ☐ Oral ☐ Anal ☐ Penile Condom use: Y ☐ N ☐

DOB: _____ Age: _____ Marital Status: S☐ M☐ D☐ W☐

Race: W☐ B☐ A☐ P☐ N☐ O: _____ Hispanic: Y ☐ N ☐

Home/Cell Phone # _____ Texting only? Y ☐ N ☐

Will they answer? Y☐ N ☐ Best time to call_____

Social media or Internet _____ Email Address _____

Where did you meet? _____

Home address _____

Directions to home _____

_____

Type of home _____ Color _____ Fenced yard_____

Animals_____ Cars usually in driveway _____

Other residents _____ Names of children_____

Employer_____ Hours _____ Work Phone _____

If attends school, where? _____ Make/model of car _____

Physical Description: Height _____ Weight/build _____ Hair color _____

Hair style _____ Facial hair _____

Visible tattoos _____

Glasses, braces, scars, piercings, etc. _____