

# At-Home STD Test

Patient information	
Name:	Date of birth:
Gender:	Date of test:
Test type	Reason for testing
<p><b>Please check all that apply:</b></p> <div><input type="checkbox"/> Chlamydia</div> <div><input type="checkbox"/> Gonorrhea</div> <div><input type="checkbox"/> Syphilis</div> <div><input type="checkbox"/> HIV</div> <div><input type="checkbox"/> Others, specify:</div>	<p><b>Please check all that apply:</b></p> <div><input type="checkbox"/> Symptoms (e.g., discharge, sores, pain, etc.)</div> <div><input type="checkbox"/> Routine checkup</div> <div><input type="checkbox"/> Recent exposure (e.g., unprotected sex, new partner)</div> <div><input type="checkbox"/> Follow up after treatment</div> <div><input type="checkbox"/> Others, specify:</div>
Sample collection details	
Date of sample collection:	
<p><b>Collection method used:</b></p> <div><input type="checkbox"/> Swab (      Oral,      Vaginal,      Anal,      Penile)</div> <div><input type="checkbox"/> Urine</div> <div><input type="checkbox"/> Blood</div> <div><input type="checkbox"/> Others, specify:</div>	
Results	
<i>To be filled out by laboratory or clinical professional</i>	
Test results sent to:	
Date results processed:	
Results summary:	

Chlamydia:	Negative	Positive
Gonorrhea:	Negative	Positive
Syphilis:	Negative	Positive
HIV:	Negative	Positive
Others, specify:	Negative	Positive

Additional notes