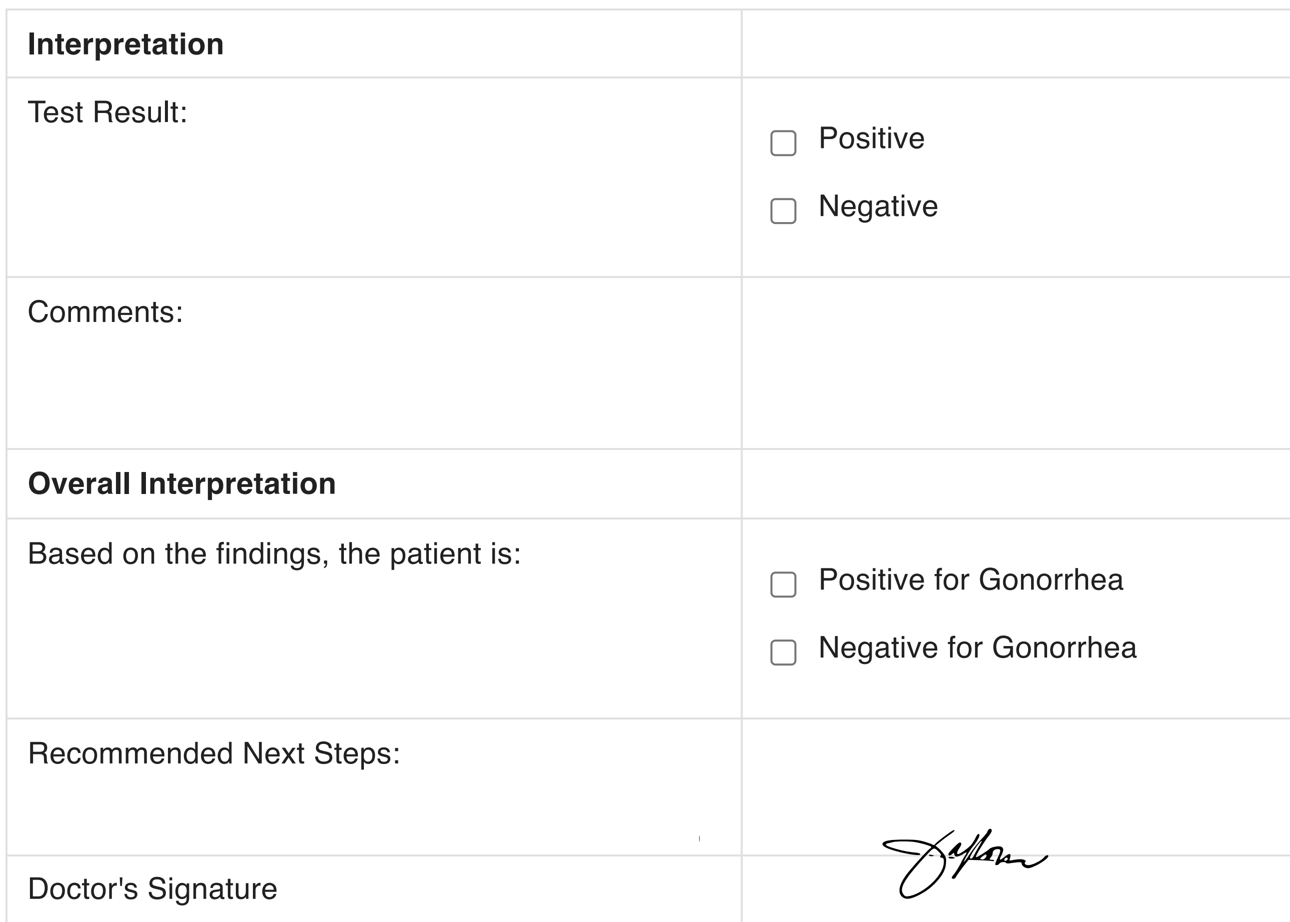
Gonorrhea Test

Patient Information	
Full Name:	
Date of Birth:	
Gender:	
Contact Number:	
Address:	
Medical History & Related Questions	
Have you ever been diagnosed with an STI before?	☐ Yes ☐ No
If yes, specify:	
Have you experienced any symptoms? (e.g., discharge, pain)	☐ Yes ☐ No
If yes, describe:	
Date of last sexual activity:	
Tests	
Sample Type:	☐ Urine ☐ Swab
Date Collected:	
Findings	
Presence of Neisseria gonorrhoeae bacteria:	☐ Detected ☐ Not Detected
Result Value:	
Normal Range:	



Interpretation	
Test Result:	☐ Positive ☐ Negative
Comments:	
Overall Interpretation	
Based on the findings, the patient is:	☐ Positive for Gonorrhea ☐ Negative for Gonorrhea
Recommended Next Steps:	
Doctor's Signature	