Herpes Simplex Virus (HSV) Screening Form

Patient Information:

Name:

Date of Birth: **Age:** **Gender:**

Medical Record Number:

Date of Screening:

Reason for Testing:

- ☐ Suspected infection
- ☐ Routine screening
- ☐ Partner diagnosed with HSV
- ☐ Previous diagnosis of another STI
- ☐ Pregnancy
- ☐ Other: _____

Clinical History:

1. Are you currently experiencing any symptoms?
   - ☐ Yes
   - ☐ No

   If yes, please describe: _____
2. Have you ever been diagnosed with or suspected having HSV in the past?
   - ☐ Yes
   - ☐ No

   If yes, when? _____
3. Have you had unprotected sexual contact in the past 6 months?
   - ☐ Yes
   - ☐ No
4. Have you or your partner had multiple sexual partners in the past 6 months?
   - ☐ Yes
   - ☐ No

Testing Details:

1. **Type of Test:**

   - ☐ HSV-1 serological test
   - ☐ HSV-2 serological test
   - ☐ Polymerase Chain Reaction (PCR) test
   - ☐ Culture of lesion
   - ☐ Other: _____

2. **Sample Collection Site:**

   - ☐ Blood
   - ☐ Oral swab
   - ☐ Genital swab
   - ☐ Other: _____

Consent:

I, _____, understand the purpose, benefits, and potential risks of the HSV test. I voluntarily agree to undergo the test and understand that I will be informed of the results in a confidential manner.

Signature: _____ Date: _____