Trichomoniasis Test Form

Patient Information

- **Full Name:** Jane A. Doe
- **Date of Birth:** 01/15/1985
- **Gender:** Female
- **Contact Number:** (123) 456-7890
- **Address:** Wellness City, HealthState, 12345

Medical History

- **Date of Last Menstrual Period (for females):** 09/01/2023
- **Previous STI Diagnoses (if any):** None
- **Current Medications:** Ibuprofen for occasional pain

Symptoms (Please check all that apply)

- [x] Itching or irritation in the genital area
- [ ] Burning sensation during urination
- [ ] Unusual discharge
- [ ] Pain during intercourse
- [ ] Redness or soreness
- [ ] No symptoms

Sexual History (Last six (6) months)

- **Number of Sexual Partners:**
- **Use of Protection:**
  - [x] Always
  - [ ] Sometimes
  - [ ] Never
- **History of Partner(s) with STIs:**
  - [ ] Yes
  - [ ] No
  - [x] Unsure

Sample Collection

- **Type of Sample:**
  - ☑ Vaginal Swab
  - ☐ Urethral Swab
  - ☐ Urine Sample
- **Date of Collection:** 10/20/2023
- **Collected by (Healthcare Professional's Name):**

Laboratory Results

- **Test Result:**
  - ☑ Positive
  - ☐ Negative
- **Date of Result:** 10/22/2023
- **Comments:** Patient should be informed of the positive result and advised on the next steps.

Recommendations

- ☑ Antibiotic Treatment
- ☐ Follow-up Testing
- ☐ Referral to Specialist
- ☑ Patient Education and Counseling

Physician's Signature: Dr. John Smith **Date:** 10/22/2023