

Trichomoniasis Test Form

Patient Information

- **Full Name:**
- **Date of Birth:**
- **Gender:**
- **Contact Number:**
- **Address:**

Medical History

- **Date of Last Menstrual Period (for females):**
- **Previous STI Diagnoses (if any):**
- **Current Medications:**

Symptoms (Please check all that apply)

- 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:**
 - Always
 - Sometimes
 - Never
- **History of Partner(s) with STIs:**
 - Yes
 - No
 - Unsure

Sample Collection

- **Type of Sample:**

- Vaginal Swab
- Urethral Swab
- Urine Sample

- **Date of Collection:**

- **Collected by (Healthcare Professional's Name):**

Laboratory Results

- **Test Result:**

- Positive
- Negative

- **Date of Result:**

- **Comments:**

Recommendations

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

Physician's Signature:

Date: