Scott County Health Department
600 W. 4th Street | Davenport, IA 52801-1030 | P. 563-326-8618 | F. 563-326-8774
health@scottcountyiowa.com | www.scottcountyiowa.com/health

Syphilis Reporting Form

CLIENT DEMOGRAPHICS

Last Name: _____ **First Name:** _____
(Please print) (Please print)

Date of Birth: _____ / _____ / _____ **Sex:** ☐ Male ☐ Female ☐ Decline **Marital Status:** ☐ S ☐ M ☐ W ☐ D ☐ Sep

Address: _____ **City:** _____

State: _____ **Zip Code:** _____ **Home Phone:** ( ) _____ - _____

Cell Phone: ( ) _____ - _____ **Work Phone:** ( ) _____ - _____

Race: ☐ White ☐ Black ☐ Asian ☐ American Indian ☐ Pacific Islander ☐ Other

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Unknown **Pregnant:** ☐ Yes [**Due Date**_____] ☐ No ☐ Unknown

History of Injecting Drug Use: ☐ Never Used ☐ Current User ☐ Previous User

EXAM – TEST INFORMATION

Medical Facility: _____ **Provider Phone:** _____

Ordering Provider: _____ **Test Collection Date:** _____ / _____ / _____

Non-Treponemal Test: ☐ RPR ☐ VDRL ☐ None Performed **Result:** ☐ Nonreactive ☐ Reactive - Titer: _____

Confirmatory Treponemal Test: ☐ TPPA ☐ FTA-ABS ☐ Other: _____ **Result:** ☐ Nonreactive ☐ Reactive

Laboratory: ☐ LabCorp ☐ Quest ☐ State Hygienic Laboratory ☐ Other: _____

HIV Test Performed at this visit: ☐ Not tested ☐ Yes, tested negative ☐ Yes, tested **POSITIVE** ☐ No, previously positive

- If previously tested HIV positive - **Diagnosis Date**: ____ / _____ / _____
- Medical Provider: _____

Lumbar Puncture Performed: ☐ No ☐ Yes (Procedure Date: _____ / _____ / _____)

HIV PrEP Status: ☐ Not on PrEP ☐ On PrEP ☐ Previously on PrEP, Last Date: _____ / _____ / _____ ☐ Declined PrEP

Last Name: _____ First Name: _____ **Date of Birth:** _____ / _____ / _____

DIAGNOSIS INFORMATION

☐ **New Syphilis Case:** ☐ Primary ☐ Secondary ☐ Early Latent ☐ Late Latent or Unknown Duration ☐ Neuro-Syphilis

☐ **Old Case:** Follow up titer only. Previously positive for syphilis. List the previous two titers and date, if available.

- Collection Date: _____ / _____ / _____ ☐ RPR ☐ VDRL: Titer: _____ Provider: _____
- Collection Date: _____ / _____ / _____ ☐ RPR ☐ VDRL: Titer: _____ Provider: _____

SYMPTOMS

☐ No Clinical Symptoms ☐ Auditory Abnormalities ☐ Condyloma Lata ☐ Chancre

☐ Mucocutaneous Lesion ☐ Ophthalmic Abnormalities ☐ Lymphadenopathy ☐ Skin rash

☐ Other Clinical Symptoms: _____

TREATMENT

Prescribed Medication(s):

☐ Benzathine Penicillin G 2.4 million units IM in a single dose **Treatment Date**: _____ /_____ /_____

☐ Benzathine Penicillin G 2.4 million units IM x 3 weekly doses ***Document Treatment Dates Below***

Dose #1: _____ /_____ /_____, **Dose #2:** _____ /_____/_____, **Dose #3** _____ /_____ /_____

☐ Doxycycline 100 mg orally twice a day for 14 days **Treatment Date**: _____ /_____ /_____

☐ Doxycycline 100 mg orally twice a day for 28 days **Treatment Date**: _____ /_____ /_____

☐ Aqueous Crystalline Penicillin G IV **Dose/Freq.:** _____ **Treatment Date**: _____ /____ /_____ **Days**: ____

☐ Other Medication: _____ Treatment Date: _____ /_____ /_____

☐ Other Medication: _____ Treatment Date: _____ /_____ /_____

SYPHILIS MANAGEMENT

Return for F/U Serology: ☐ 3 months ☐ 6 months ☐ 9 months ☐ 12 months ☐ 24 months

Additional Information: _____

_____

_____

_____

_____

_____

_____

Date Faxed: _____ Nurse's Initial: _____

Fax this report to SCHD Sexual Health Program (563) 326-8774