HPTN 052 (096) ISS-1 (132) **Visit Code** ___.___ 1

Index ID

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Site Number | Index Number | Partner | Chk

Index Symptomatic Sexually Transmitted Diseases

Visit Date

__ __ *dd* | ___ *MMM* | __ __ *yy*

***Instructions**: Complete this form when a participant is treated for symptoms of a sexually transmitted disease.*

1. Indicate if the participant was treated for symptoms of any of the following sexually transmitted diseases.

		yes	*no*
1a.	chlamydia	☐	☐
1b.	gonorrhea	☐	☐
1c.	syphilis	☐	☐
1d.	BV (bacterial vaginosis)	☐	☐
1e.	TV (trichomonas vaginalis)	☐	☐
1f.	candida	☐	☐
1g.	genital ulcer disease	☐	☐
1h.	other, specify: _____	☐	☐
1i.	other, specify: _____	☐	☐

Comments: _____

_____

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No additional instructions.