



HPTN 052 (096)

PSS-1 (332)

Visit Code

Index ID

- - -
 Site Number Index Number Partner Chk

Partner 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.

	<i>yes</i>	<i>no</i>
1a. chlamydia.....	<input type="checkbox"/>	<input type="checkbox"/>
1b. gonorrhea.....	<input type="checkbox"/>	<input type="checkbox"/>
1c. syphilis.....	<input type="checkbox"/>	<input type="checkbox"/>
1d. BV (bacterial vaginosis).....	<input type="checkbox"/>	<input type="checkbox"/>
1e. TV (trichomonas vaginalis).....	<input type="checkbox"/>	<input type="checkbox"/>
1f. candida.....	<input type="checkbox"/>	<input type="checkbox"/>
1g. genital ulcer disease.....	<input type="checkbox"/>	<input type="checkbox"/>
1h. other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>
1i. other, specify: _____	<input type="checkbox"/>	<input type="checkbox"/>

Comments: _____

16-JAN-13

Language

 Staff Initials / Date

Partner Symptomatic Sexually Transmitted Diseases (PSS-1)

No additional instructions.