Alberta Health Services

Syphilis Assessment and History

- For questions regarding management of syphilis call 1-855-945-6700 option 4.
- Please fax completed form to 780-670-3624.
- For privacy and compliance purposes, do not save or store this form if it contains any patient health information.

Demographics

Last Name	First Name	Middle Name

Date of Birth *(dd-Mon-yyyy)*	Personal Health Number

Administrative Gender ☐ Male ☐ Female ☐ Non-binary/Prefer not to disclose (X) ☐ Unknown

Gender Identity ☐ Transgender Male ☐ Transgender Female ☐ Other _____

Street Address ☐ Homeless	City or Town	Province	Postal Code

Phone #	Alternative Phone #

Other Locating info *(e.g. Facebook, email, places known to frequent)*

Ethnicity

☐ African/Caribbean/Black ☐ Asian (East/SE) ☐ Caucasian
☐ First Nation ☐ Inuit ☐ Latin American
☐ Metis ☐ Middle Eastern/Arab ☐ Other Asian
☐ Unknown ☐ Other *(specify)* _____

Lives on Reserve ☐ Yes ▼ ☐ No ☐ Unknown

Name of First Nations Community _____

Country of Birth	Arrival date in Canada *(dd-Mon-yyyy)*	Location of Immigration medical

History

Pregnant ☐ Yes ► Estimated Date of Delivery (EDD) *(dd-Mon-yyyy)* _____
☐ No ► Date of Last Menstual Period *(dd-Mon-yyyy)* _____

Pregnancy/delivery/loss in the past year
☐ Yes ► Date of delivery *(dd-Mon-yyyy)* _____ ☐ No

Outcome

☐ Live Birth ☐ Spontaneous Abortion ☐ Therapeutic Abortion
☐ Stillbirth ☐ Pending ☐ Unknown

Current Social/Behavioural History *(Check all that apply)*

☐ Sex with Males ☐ Sex with Females
☐ People who inject drugs ☐ Sex with People who inject drugs
☐ Patron: Exchange Goods/Money for Sex ☐ Worker: Exchange Goods/Money for Sex
☐ Anonymous Partner

Sexual History

Most Recent Sexual Contact Date *(dd-Mon-yyyy)* _____

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Reason for Testing			
☐ STI Screening	☐ Symptoms	☐ Contact	☐ Pre/Postnatal
☐ Sexual Assault	☐ Immigration Medical	☐ Positive Serology	☐ Therapeutic Abortion
☐ Other *(Specify)* _____			

Clinical Findings for Syphilis	Yes	No	Unknown	Declined to answer	Duration/Description
Symptomatic	☐	☐	☐	☐	
Chancre	☐	☐	☐	☐	
Condyloma Lata	☐	☐	☐	☐	
Rash	☐	☐	☐	☐	
Alopecia	☐	☐	☐	☐	
Fever/Malaise	☐	☐	☐	☐	
Lymphadenopathy	☐	☐	☐	☐	
CNS ***(vision or auditory change/loss, ataxia, dementia)***	☐	☐	☐	☐	
CVS ***(recent stroke/cardiac event)***	☐	☐	☐	☐	
Other ***(specify)*** ***(new onset leg edema)***	☐	☐	☐	☐	

Additional Notes

Medical History			
Penicillin Allergy	☐ Yes	☐ No	☐ Unknown
Penicillin Reaction			
Other medication allergies			
Medication/Antibiotics in Past 30 Days	☐ Yes	☐ No	☐ Unknown
Name	Date *(dd-Mon-yyyy)*		
HIV PrEP in last 12 months ☐ Yes ☐ No ☐ Unknown	Last Dose Date *(dd-Mon-yyyy)*		

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Previous Syphilis History *(if diagnosed outside Alberta)*			
Previous Diagnosis	☐ Yes	☐ No	☐ Unknown
Describe *(i.e. chancre, rash, serology results)*			
If Yes, Previous Staging	☐ Infectious	☐ Non-Infectious	☐ Unknown
Other *(Specify)*			
Previous Treatment	☐ Yes	☐ No	☐ Unknown
Previous Treatment Date *(dd-Mon-yyyy)*		Previous Treatment Location	
Medication and Dosage Given			

Current Treatment	
*Note: Administer benzathine penicillin 2.4mu IM as a divided dose. 1.2mu to each left and right ventrogluteal muscle.	
Medication	**Treatment Date** *(dd-Mon-yyyy)*
☐ Benzathine Penicillin 2.4 mu IM weekly x 1 week	Dose 1 _____
☐ Benzathine Penicillin 2.4 mu IM weekly x 2 week	Dose 2 _____
☐ Benzathine Penicillin 2.4 mu IM weekly x 3 week	Dose 3 _____
☐ Doxycycline 100mg PO bid x 14 days	
☐ Doxycycline 100mg PO bid x 28 days	
Treating Provider's Name	
Treatment Address	

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■ Please send additional contacts on the Sexual Contact Information form if needed.

☐ Declined to provide contacts.
Anonymous contacts ☐ No ☐ Yes # of contacts in past 12 months _____

Sexual Contact Information			
First Name	Middle Name	Last Name	
Gender ☐ Female	☐ Male	☐ Non-binary	☐ Unknown
Date of Birth *(dd-Mon-yyyy)*	Age	Marital Status	
Street Address		City/Town	
Province/Country	Postal Code	Phone Number	Alternate Phone Number
Other Locating Info *(e.g Facebook, email, places known to frequent)*			
Exposure Date *(dd-Mon-yyyy)*	Location of Exposure		
Ethnicity	Distinguishing Features		
Relationship to Patient: ☐ Current regular partner ☐ Casual known ☐ Ex-regular partner ☐ Anonymous partner ☐ Exchange goods/money for sex			
Treated ☐ Yes	☐ No	☐ Unknown	
Treatment Date *(dd-Mon-yyyy)*	Medication		

Sexual Contact Information			
First Name	Middle Name	Last Name	
Gender ☐ Female	☐ Male	☐ Non-binary	☐ Unknown
Date of Birth *(dd-Mon-yyyy)*	Age	Marital Status	
Street Address		City/Town	
Province/Country	Postal Code	Phone Number	Alternate Phone Number
Other Locating Info *(e.g Facebook/Email)*			
Exposure Date *(dd-Mon-yyyy)*	Location of Exposure		
Ethnicity	Distinguishing Features		
Relationship to Patient: ☐ Current regular partner ☐ Casual known ☐ Ex-regular partner ☐ Anonymous partner ☐ Exchange goods/money for sex			
Treated ☐ Yes	☐ No	☐ Unknown	
Treatment Date *(dd-Mon-yyyy)*	Medication		