GENITAL DISCHARGE - MALE

Subjective Data:  

Allergies: ____________________________

Chief complaint: ____________________________________________

Onset: ________  □ Chronic  □ Recurrence

History:

Sexually transmitted disease: □ None  □ Gonorrhea  □ Syphilis  □ Herpes  □ Chlamydia  □ Venereal warts

Antibiotic therapy: When: ____________  Name of medication: ____________________________________________

Last sexual intercourse: _____________

Associated Symptoms:

□ Burning / painful urination  □ Frequency  □ Urgency  □ Dribbling  □ Inability to void

□ Foul odor to urine  □ Back pain  □ Abdominal pain  □ Painful ejaculation

Objective Data: (clinically indicated VS)

BP ___________ Pulse _________ Resp. ________ Temp. ________ Wt. ________ O2 sats. ________ FSBS: ___________

<table>
<thead>
<tr>
<th>Genitalia</th>
<th>Skin</th>
<th>Urine</th>
<th>Mouth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal</td>
<td>Rash</td>
<td>Clear</td>
<td>Ulcers</td>
</tr>
<tr>
<td>Ulcers</td>
<td>Other lesions</td>
<td>Cloudy</td>
<td>Purulent tonsils</td>
</tr>
<tr>
<td>Warts/skin tags</td>
<td></td>
<td>Dark</td>
<td></td>
</tr>
<tr>
<td>Clear discharge</td>
<td></td>
<td>Foul odor</td>
<td>Exudate</td>
</tr>
</tbody>
</table>

CONTACT HEALTH CARE PROVIDER/RN IMMEDIATELY IF: Health care provider must be called if not on site or if after clinic hours.

□ Temp > 101

REFER TO HEALTH CARE PROVIDER IF: If during clinic hours the health care provider is to be called if not on site. If after clinic hours the health care provider is to be called the next working day.

□ Any discharge or genital lesions are present

Health Care Provider Notified: Date: ___________ Time: ___________ Orders Received for Treatment: □ Yes □ No

Plan: Interventions: (check all that apply)

□ Check in assessment only for health care providers visit.

□ Chief complaint resolved prior to appointment. Instructed inmate to follow-up sick call for signs/symptoms warranting further evaluation. Assessment completed.

□ Clean catch urine specimen.

□ Prepare for urethral culture if discharge present and ordered by health care provider.

□ Education/Intervention: Instructed to protect scrotal or groin area, avoid strenuous physical activity, medication use, follow-up sick call if no improvement. Inmate verbalizes understanding of instructions.

Progress Note: ________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Health Care Provider Signature/Credentials: ___________________________ Date: ___________ Time: ___________

RN/LPN Signature/Credentials: ___________________________ Date: ___________ Time: ___________

Inmate Name  DOC #

(Last, First)