

***Chlamydia trachomatis* Antibiotic Resistance Enhanced Surveillance
(Female Patients)**



GU Clinic Number:	GUM Clinic:
Date of Birth:	Date Reported:

1. Ethnicity:

White

British Irish Other

Black

Caribbean African Other

Asian

Indian Bangladeshi Pakistani Other

Chinese

Other

Unknown

2a. **Date of initial Chlamydia positive test:** ___/___/___

2b. Recent Sexual History (last 3 months):

New sexual partner?

Yes No Unknown

Multiple sexual partners?

Yes No Unknown

Sex abroad?

Yes No Unknown

If yes, location: _____

Sex of partner(s)

Male Female

Both Unknown

2c. Symptoms (tick all that apply)

Discharge

Deep dyspareunia

IMB/PCB

Lower abdominal pain

2d. Signs (tick all that apply)

Cervicitis

Pelvic inflammatory disease

SARA

2e. Detection Methodology for *C. trachomatis* (please detail):

NAAT

EIA

Other, please state: _____

Diagnosis not confirmed

2f. Treatment:

Azithromycin 1g stat

Doxycycline 100mg bd 7/7

Other (please give details with dates) _____

3. Past history of *C. trachomatis*?

Yes; Date of diagnosis: _____; KC60 code: _____

No

Unknown

4a. **Date of Chlamydia positive retest:** ___/___/___

4b. Detection Methodology (please detail):

NAAT

EIA

Other, please state: _____

Diagnosis not confirmed

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(Female Patients)**



4c. Symptoms (tick all that apply)

- Discharge
- Deep dyspareunia
- IMB/PCB
- Lower abdominal pain

4d. Signs (tick all that apply)

- Cervicitis
- Pelvic inflammatory disease
- SARA

4e. Medication taken correctly?

- Azithromycin 1g stat
 Yes No Unknown

- Doxycycline 100mg bd
 Yes No Unknown

Number of days missed _____

Number of tablets missed: _____

Other therapy, _____

- Yes No Unknown

Number of days missed _____

Number of tablets missed: _____

5a. Has the patient been sexually active since starting treatment?

- Yes No Unknown (If yes, please answer the following)

5b. Sexual History following initial Chlamydia diagnosis:

	1 st Partner	2 nd Partner	3 rd Partner	4 th Partner
After receiving treatment, how many days elapsed before the patient had sexual intercourse with each partner?	_____ (days)	_____ (days)	_____ (days)	_____ (days)
Had the patient had sexual intercourse with this partner in the 6 months prior to diagnosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Had the patient completed treatment prior to sexual intercourse?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Has this partner tested positive for Chlamydia in the past 3 months (if yes, please provide treatment details below)?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown			
Sex of the partner	<input type="checkbox"/> Male <input type="checkbox"/> Female			
Type of sexual intercourse (tick all that apply)	<input type="checkbox"/> Vaginal <input type="checkbox"/> Anal <input type="checkbox"/> Oral			
Did they use a condom?	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Never <input type="checkbox"/> Unknown	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Never <input type="checkbox"/> Unknown	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Never <input type="checkbox"/> Unknown	<input type="checkbox"/> Always <input type="checkbox"/> Usually <input type="checkbox"/> Never <input type="checkbox"/> Unknown

6. Comments: