

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. _____

Genitalia	Skin	Urine	Mouth
<input type="checkbox"/> Normal	<input type="checkbox"/> Rash	<input type="checkbox"/> Clear	<input type="checkbox"/> Ulcers
<input type="checkbox"/> Ulcers	<input type="checkbox"/> Other lesions	<input type="checkbox"/> Cloudy	<input type="checkbox"/> Purulent tonsils
<input type="checkbox"/> Warts/skin tags		<input type="checkbox"/> Dark	<input type="checkbox"/> Exudate
<input type="checkbox"/> Clear discharge		<input type="checkbox"/> Foul odor	

(Nursing Protocol must be signed by the Medical Provider if offender displays any of the below s/s or any additional treatment/ medication required)

NOTIFY MEDICAL PROVIDER IMMEDIATELY IF:

Temp > 101

Refer to Medical Provider if:

Any discharge or genital lesions are present

Medical Provider Notified: Date: _____ **Time:** _____ **Orders Received for Treatment:** Yes No

Assessment:

Alterations in comfort related to genital infection

Plan: Nursing Intervention Routine: (check all that apply)

Check in assessment only for medical providers visit.

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

Clean catch urine specimen

Prepare for urethral culture if discharge present and ordered by medical provider

Education/Intervention: Instructed in proper hygiene care, medication use, follow-up sick call if no improvement. Offender verbalizes understanding of instructions.

Progress Note: _____

Medical Provider Signature/Credentials: _____ **Date:** _____ **Time:** _____

QHCP Signature/credentials: _____ **Date:** _____ **Time:** _____

Offender Name
(Last, First)

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