



THE CITY OF NEW YORK

DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Michael R. Bloomberg
Mayor

Thomas R. Frieden, M.D., M.P.H.
Commissioner

nyc.gov/health

To: New York City Health Care Providers

From: Susan Blank, MD, MPH
Assistant Commissioner, Bureau of STD Control, NYC DOHMH

Date: March, 2005

Subject: **STD Practices of New York City Providers**

The New York City Department of Health & Mental Hygiene, Bureau of Sexually Transmitted Disease Control (NYC DOHMH BSTDC) is conducting a survey of New York City health care providers. We have previously sent you this survey and have not heard back from you. **If you have not completed this survey, we urge you to please consider doing so.**

The goal of this survey is to understand your knowledge, opinions, and practices regarding sexually transmitted disease (STD) diagnosis, treatment, screening, reporting and partner notification. Findings from this survey will be used in part to guide the development of future clinical training courses for STDs. A number of organizations, both governmental and non-governmental, have guidelines for STD practices. We believe that it is crucial that policy makers are informed of practicing clinicians' views related to these responsibilities.

Your answers to this survey will not be linked to your name or any other identifying information. You may choose to skip any questions that you do not wish to answer. Your responses will be grouped with those of several hundred providers that complete this survey. We greatly appreciate your taking the time to complete this survey, as the information you can provide is essential to us. Thank you!

If you have any questions concerning the survey, please contact Meighan Rogers, MPH at 212-788-4428 or mrogers@health.nyc.gov.

Sincerely,

Susan Blank, MD, MPH
Assistant Commissioner
Bureau of STD Control

Please return the survey to the address provided on the last page

SECTION A: CLINICIAN AND PRACTICE CHARACTERISTICS

I. Please write your initials here (for tracking purposes only): _____

II. Do you currently deliver direct patient care within the 5 boroughs of New York City? Yes No



If you do not deliver patient care within NYC, please STOP here. This is ONLY an assessment of providers that practice in NYC. Please mail this form to the NYC Department of Health & Mental Hygiene at the address provided on the last page of this survey so that we can keep track of all survey responses. Thank you very much for your assistance.

Individual Clinician Characteristics

A1. What is your age? Age in Years

A2. What is your sex? Male Female

A3. Are you Hispanic or Latino? Yes No

A4. What is your race?
Please ✓ all that apply.

White
 Black or African American
 American Indian or Alaskan Native
 Asian
 Native Hawaiian or other Pacific Islander
 Other, **please specify:** _____

A5. What type of provider are you?
Please ✓ only one.

Medical Doctor (MD)
 Doctor of Osteopathy (DO)
 Nurse Practitioner (NP)
 Physician's Assistant (PA)

A6. What year did you graduate from professional school (i.e. medical school, PA or NP school) Year.....

A7. On average, how many total hours **per week** do you spend in direct patient care? Average # of hours per week.....

A8. What is your specialty?
Please ✓ only one.

- Internal Medicine
- Family Practice/Family Medicine
- Pediatrics
- Obstetrics/Gynecology
- Emergency Medicine
- Infectious Disease
- Urology
- Dermatology
- Women's Health (NP/PA only)
- Adult Health (NP/PA only)

Other, please specify: _____

A9. During any part of your academic clinical training (i.e. medical, PA, nursing school) did you receive formal training in sexually transmitted disease diagnosis, treatment or management?

- Yes No

Primary Practice Setting

We define "primary practice setting" as the setting in which you conduct *most* of your direct patient care. Please answer the following questions based on your "primary practice setting."

A10. What is the **zip code** of your primary practice setting?

Zip code

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A11. What best describes your primary practice setting? **Please ✓ only one.**

- A primary care office
- An ambulatory care clinic of hospital/medical center
- A university/college student health service
- A community health clinic
- A public health clinic
- An urgent care clinic
- A hospital emergency room
- A family planning clinic
- An abortion clinic
- A sexually transmitted disease clinic/ unit
- An inpatient setting
- Another type of clinic

Please specify: _____

A12. Is your primary practice site in a public or private setting? **Please ✓ only one.**

A. If in a public setting, is your primary practice site part of:

- Public Private - **Please skip to B1.**
- ↓
- The U.S. Public Health Service
- A state, county, or city public health department or hospital
- A Military Treatment Facility
- The Veterans Affairs
- Other? **Please specify:** _____

SECTION B: PATIENT CHARACTERISTICS

This section asks about the characteristics of patients in your *primary practice setting*. There is no need to review your records—please give your best estimate.

PLEASE REMEMBER: Primary Practice Setting = Where you conduct most of your direct patient care.

- B1.** On average, how many patients do you see in a typical week at your primary practice setting? # patients per week..... [][][][]
- B2.** Of these patients, approximately what percent are **female**? % Female..... [][][][]
- B3.** If you see females, *approximately* what percent of your **female** patients are adolescents aged 13-19? % Female adolescent [][][][]
- N/A – Don't see female patients**
- B4.** *Approximately* what percent of your **female adolescent** patients aged 13-19 are sexually active? % Female adol. sex. active [][][][]
- N/A - Don't see female adolescents**
- Don't Know**
- B5.** *Approximately* what percent of your **male** patients are adolescents aged 13-19? % Male adolescent [][][][]
- N/A – Don't see male patients**
- B6.** *Approximately* what percent of your **male adolescent** patients aged 13-19 are sexually active? % Male adol. Sex. active [][][][]
- N/A - Don't see male adolescents**
- Don't Know**
- B7.** *Approximately* what percent of your **male** patients are men who have sex with men (MSM)? % Male pts that are MSM [][][][]
- N/A - Don't see male patients**
- Don't Know**
- B8.** *Approximately* what percent of all of your patients have HIV/AIDS? % patients with HIV/AIDS [][][][]

B9. *Approximately* what percent of your **MSM** patients have HIV/AIDS? % MSM with HIV/AIDS|_|_|_| %
 N/A – Don't see MSM
 Don't Know

B10. *Approximately* what percent of your patients are:
 White.....|_|_|_| %
 Black or African American|_|_|_| %
 American Indian or Alaska Native|_|_|_| %
 Asian.....|_|_|_| %
 Native Hawaiian or other Pacific Islander|_|_|_| %
 Other.....|_|_|_| %
TOTAL..... 100%

B11. *Approximately* what percent of your patients are of Hispanic or Latino origin? % Hispanic/Latino|_|_|_| %

B12. Please estimate as best you can the percentage of patients in your primary practice setting in each insurance group.
 Self pay/no insurance|_|_|_| %
 Private HMO/PPO/Managed Care|_|_|_| %
 Other private medical insurance|_|_|_| %
 Medicaid or comparable State Health Plan.....|_|_|_| %
 Medicaid Managed Care.....|_|_|_| %
 Other (i.e., Military, Medicare, etc.)|_|_|_| %
TOTAL..... 100%

SECTION C: SEXUALLY TRANSMITTED DISEASE DIAGNOSIS

C1. *Approximately* how many cases of the following STDs have you diagnosed in your **primary** practice setting in the past 12 months? **Please choose one category (0, 1-4, 5-10 or >10 for each STD).**

STD	Number of Cases Diagnosed in the Past Year			
	0	1-4	5-10	>10
a. Gonorrhea.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Quinolone-resistant Neisseria Gonorrhea (QRNG).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Number of Cases Diagnosed in the Past Year

STD	0	1-4	5-10	>10
c. Chlamydia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Primary or Secondary Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Latent Syphilis (Not primary or secondary syphilis).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Neurosyphilis.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Genital Herpes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Pelvic Inflammatory Disease (PID)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Non-gonococcal Urethritis (NGU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Trichomoniasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Lymphogranuloma venereum (LGV)...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Chancroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Other STD, please specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Methicilin-resistant Staph Aureus (MRSA) skin infection, any location	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Even if you see no or few STDs, please continue with the survey. Many of the questions ask for your opinions, and your opinions are important to us.

Diagnostic Testing Practices

C2.

A. What diagnostic tests do you use to diagnose HIV? *Please ✓ all that apply.*

- EIA/Western Blot
- PCR
- Oral Swab (e.g. OraSure)
- Rapid HIV Blood Test (e.g. Oraquick)
- Other: _____
- None of the above

B. What diagnostic tests do you use to diagnose Herpes Simplex Virus (HSV)? *Please ✓ all that apply.*

- Culture
- DFA
- Tzanck (Giemsa prep)
- Type-specific serologic tests
If you use serologic tests, list test name and manufacturer: _____
- Other: _____
- None of the above

- C. What diagnostic tests do you use to diagnose cervical Human Papillomavirus (HPV)?
Please ✓ *all that apply.*

- Thin prep
 Hybrid Capture II (High Risk Types)
 Hybrid Capture II (Low Risk Types)
 Hybrid Capture II (Combined Risk Types)
 Other: _____
 I do not use a diagnostic test

C3. The next set of questions are about STD screening. By screening, we mean testing patients who *do not* have any symptoms.

- A. How often do you routinely screen pregnant women for Gonorrhea and Chlamydia?
Please ✓ *only one.*

- I do not see/treat pregnant women
 I do not screen pregnant women for Gonorrhea and Chlamydia
 First visit only
 First visit and at 34 weeks
 More than twice during pregnancy
 None of the above

- B. Which groups of asymptomatic patients do you screen for the following STDs? For each STD, please check one box for the frequency of screening you conduct in that patient population.

- I do not screen any patients for STDs.

	Syphilis	Gonorrhea	Chlamydia	HIV
a. Sexually active adolescent females	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never
	<input type="checkbox"/> < 1x / yr			
<input type="checkbox"/> N/A – I don't see adolescent females	<input type="checkbox"/> 1x / yr			
	<input type="checkbox"/> > 1x / yr			
	Syphilis	Gonorrhea	Chlamydia	HIV
b. Sexually active adolescent males	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never
	<input type="checkbox"/> < 1x / yr			
<input type="checkbox"/> N/A – I don't see adolescent males	<input type="checkbox"/> 1x / yr			
	<input type="checkbox"/> > 1x / yr			
	Syphilis	Gonorrhea	Chlamydia	HIV
c. Sexually active men who have sex with men (MSM)	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never
	<input type="checkbox"/> < 1x / yr			
<input type="checkbox"/> N/A- I don't see MSM	<input type="checkbox"/> 1x / yr			
	<input type="checkbox"/> > 1x / yr			
	Syphilis	Gonorrhea	Chlamydia	
d. Sexually active HIV-positive patients	<input type="checkbox"/> Never	<input type="checkbox"/> Never	<input type="checkbox"/> Never	
	<input type="checkbox"/> < 1x / yr	<input type="checkbox"/> < 1x / yr	<input type="checkbox"/> < 1x / yr	
<input type="checkbox"/> N/A – I don't see HIV-positive patients	<input type="checkbox"/> 1x / yr	<input type="checkbox"/> 1x / yr	<input type="checkbox"/> 1x / yr	
	<input type="checkbox"/> > 1x / yr	<input type="checkbox"/> > 1x / yr	<input type="checkbox"/> > 1x / yr	

SECTION D: SEXUALLY TRANSMITTED DISEASE DIAGNOSIS, TREATMENT, REPORTING AND INFECTION CONTROL PRACTICES

Case Studies: The next three questions describe scenarios and possible strategies for clinical management. Please check the box you feel best represents your clinical practice.

D1. You see a male patient with acute non-purulent urethritis. How often do you:
Please ✓ only one box per question.

Not applicable - I do not see/treat male patients.

	Rarely 0-10%	Sometimes 11-49%	Usually 50-90%	Always 91-100%
a1. Do a diagnostic or laboratory test for Chlamydia (CT)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a2. Do a diagnostic or laboratory test for Gonorrhea (GC)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Treat the patient presumptively for:				
Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trich?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Genital Herpes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Conduct a sexual history on the patient?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Tell the patient not to have sex with any partners during the treatment period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Talk to the patient about the importance of using condoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Talk to patient about why it is important that the patient inform his sex partner(s) of his infection?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Instruct patient to tell partner(s) to seek care for diagnosis and treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Collect partner information from patient and have your office contact partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Report patient name to Health Dept if diagnosis is lab confirmed CT or GC?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Report patient name to Health Dept if diagnosis is NGU?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D2. You see an adolescent female patient with muco-purulent cervicitis on exam. How often do you: Please ✓ only one box per question.

Not applicable - I do not see/treat female patients.

	Rarely 0-10%	Sometimes 11-49%	Usually 50-90%	Always 91-100%
a1. Do a diagnostic or laboratory test for Chlamydia (CT)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a2. Do a diagnostic or laboratory test for Gonorrhea (GC)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Treat the patient presumptively for:				
Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Conduct a sexual history on the patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Tell the patient not to have sex with any partners during the treatment period?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Talk to the patient about the importance of using condoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Talk to patient about why it is important that the patient inform her sex partner(s) of her infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Instruct patient to tell partner(s) to seek care for diagnosis and treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Collect partner information from patient and have your office contact partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Report patient name to Health Dept if diagnosis is CT or GC?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Report patient name to Health Dept if diagnosis is NGU?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Arrange a visit for repeat test in 3-4 mo?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D3. You see an adult male patient with signs of secondary syphilis, including rash. At the initial visit for this patient, how often do you: Please ✓ only one box per question.

Not applicable - I do not see/treat male patients.

	Rarely 0-10%	Sometimes 11-49%	Usually 50-90%	Always 91-100%
a. Order a diagnostic serologic test for syphilis, (RPR/VDRL)?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Specifically request a confirmatory syphilis test? (FTA or TP-PA)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Treat the patient presumptively for syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Ask the patient if he has recently tested for HIV?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Conduct a sexual history on the patient?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

	Rarely 0-10%	Sometimes 11-49%	Usually 50-90%	Always 91-100%
f. Ask the patient about the sex of his partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Tell the patient not to have sex with any partners during the treatment period?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Talk to the patient about the importance of using condoms?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Talk to patient about why it is important that the patient inform his sex partner(s) of his infection?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Instruct patient to tell partner(s) to seek care for diagnosis and treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Give patient antibiotic for partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Collect partner information from patient and have your office contact partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Report patient name to Health Dept if lab confirmed syphilis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Arrange f/u visit for a serologic re-test?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D4. The following questions assess general sexual/reproductive health and STD testing practices. During a routine, non-problem oriented visit, how often do you:
Please ✓ only one box per question.

	Rarely 0-10%	Sometimes 11-49%	Usually 50-90%	Always 91-100%
a1. Perform a sexual history on <i>male</i> adolescent patients aged 15-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
a2. Perform a sexual history on <i>female</i> adolescent patients aged 15-19?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Perform a sexual history on adult pts?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Perform a pelvic exam on adolescent and young adult female patients?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Perform an anal pap smear on patients who have had anal intercourse?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Dispense emergency contraception when a patient has recently had uncontracepted sex?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Screen men who have sex with men (MSM) who have had receptive anal intercourse for rectal Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Screen MSM who have had receptive anal intercourse for rectal Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Screen MSM who have had oral-genital exposure for oral Gonorrhea?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Screen MSM who have had oral-genital exposure for oral Chlamydia?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D5.

- a. Do you routinely screen all adolescent *females* for Chlamydia, *regardless* of whether the patient is sexually active? Yes No
- b. Do you routinely screen all adolescent *males* for Chlamydia, *regardless* of whether the patient is sexually active? Yes No

**D6. The following questions assess whether you provide treatment for sex partners of patients that you have diagnosed with an STD. How often do you:
Please ✓ only one box for each question.**

	Never 0%	Sometimes 1-49%	Usually 50-90%	Always 91-100%
a. Give a patient you have diagnosed with Chlamydia a dose of antibiotic or a prescription for his/her partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Give a patient you have diagnosed with Gonorrhea a dose of antibiotic or a prescription for his/her partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Give a patient you have diagnosed with Trichomonas vaginalis (Trich) a dose of antibiotic or a prescription for his/her partner(s)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- D7.** When an effective HPV vaccine becomes available, it should be given prior to sexual debut to prevent cervical cancer
- | | | |
|--------------------------|--------------------------|--------------------------|
| Agree | Disagree | Uncertain |
| <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

- D8.** What regimen do you usually use to treat males with Gonorrhea? **Please list answer in the following format: Medication, Dose, Route, Frequency, Duration** (e.g. Doxycycline 100mg po BID x 7d)

Gonorrhea Regimen: _____

- D9.** Which of the following describes your prescribing practices for herpes antiviral medications? (i.e. acyclovir, valcyclovir)? **Please ✓ all that apply.**
- I do not prescribe herpes antiviral medications
 - As episodic therapy for patients with recurrent outbreaks, to be taken when prodromal symptoms occur
 - As chronic prophylaxis (taken routinely) to prevent outbreaks in a patient with recurrent outbreaks
 - As chronic prophylaxis (taken routinely) to prevent shedding in a patient who is asymptomatic (has no outbreaks), but is known to be infected
 - As chronic suppressive herpes therapy for HIV-infected patients
 - I have another prescribing practice: Please specify:

SECTION E: STD REPORTING PRACTICES

E1. Which of the following STDs are reportable by law *by providers* in NYC?
Please ✓ “Yes,” “No,” or “Uncertain” for each STD.

	Reportable by Providers		
	Yes	No	Uncertain
a. Gonorrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Chlamydia.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Syphilis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Non-gonococcal urethritis (NGU)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. HIV infection w/o AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. AIDS	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Lymphogranuloma venereum (LGV)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Chancroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Granuloma Inguinale	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

SECTION F: PROVIDER BELIEFS

You may have certain beliefs or expect certain consequences when reporting STDs diagnosed in your patients to your local Health Department. Below is a list of beliefs or consequences for each of these actions.

Please rate how strongly you agree or disagree with each of the following statements.

F1.	Reporting STD cases to the Health Department:	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
		1	2	3	4	5
a.	Would take too much of my (or my staff's) time.....	<input type="checkbox"/>				
b.	Would get the patient upset with me	<input type="checkbox"/>				
c.	Results in actions that are intrusive to my patient.....	<input type="checkbox"/>				
d.	Protects my patients from reinfection....	<input type="checkbox"/>				
e.	Is not my responsibility.....	<input type="checkbox"/>				
f.	Is what most of my colleagues do	<input type="checkbox"/>				
g.	Violates patient confidentiality	<input type="checkbox"/>				
h.	Is a legal requirement in my state	<input type="checkbox"/>				
i.	Violates HIPAA	<input type="checkbox"/>				

SECTION G. PROVIDER PROFICIENCY LEVELS

Please rate your current proficiency in each of the following skill areas, and whether you are interested in obtaining additional training.

G1.	Current Proficiency In:	Proficiency Level				I am interested in additional training
		Limited	Fair	Good	Excellent	
a.	Taking a sexual history from adolescent patients aged 15-19	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b.	Taking a sexual history from adult patients.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c.	Performing a pelvic exam.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d.	Discussing sexual health issues with patients who have same-sex partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e.	Discussing adolescent sexual activity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f.	Discussing contraception	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g.	Discussing <i>emergency</i> contraception.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h.	Explaining the importance of notifying potentially exposed sex partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i.	Calculating the correct time period for which sex partners should be elicited (differs by disease)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j.	Asking a patient to provide names of sex and needle sharing partners	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k.	Asking married patients about any partners outside the marriage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l.	Assessing patient concerns about risk of domestic or relationship violence/harm from partner(s)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m.	Describing the services available through the health department's partner notification program	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G2.	Does your office have a written protocol for screening HIV-infected persons for syphilis? ...	<input type="checkbox"/> Yes		<input type="checkbox"/> No		
G3.	Have you ever referred to CDC's STD Treatment Guidelines? Please ✓ only one.	<input type="checkbox"/> Many Times		<input type="checkbox"/> Occasionally		<input type="checkbox"/> Once or Twice
G4.	Are you aware that New York City is currently having a syphilis outbreak among men who have sex with men?	<input type="checkbox"/> Yes		<input type="checkbox"/> No		

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NYC DOHMH
Bureau of STD Control
125 Worth Street, CN73
New York, NY 10013
Attn: Meighan Rogers, Room 207

**The information you have provided is very valuable to us.
We appreciate your time and effort!**