ANNUAL SEXUAL HEALTH REVIEW

BASIC INFORMATION

1. Preferred name: _____

Preferred pronouns:

☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other:_____

2. What gender do you identify as?

☐ Man ☐ Woman ☐ Transgender(MtF) ☐ Transgender(FtM) ☐ Other

3. What sex were you assigned at birth?

☐ Male ☐ Female ☐ Other:_____

4. Country of birth? _____ **Primary language?** _____

VISIT DATE:

- CLINIC USE ONLY -

GENERAL HEALTH HISTORY

5. Check below if you have (or had) any of the following conditions:

☐ Allergies (food, drugs, insects, latex)
☐ Bladder or kidney problems
☐ Blood disease or bleeding problem
☐ Developmental delay / autism
☐ Diabetes (sugar)
☐ Dialysis
☐ Diarrhea / constipation / bowel problems
☐ Heart problems / murmurs
☐ Hepatitis or liver disease
☐ High blood pressure / stroke
☐ Intellectual disability / learning problems
☐ Mental health issues (depression, anxiety, etc.)
☐ Osteoporosis / osteopenia
☐ Seizures / epilepsy
☐ Skin problems
☐ Throat problems
☐ Thyroid problems
☐ Tuberculosis or lung problem
☐ Vision / eye problems
☐ G6PD deficiency
☐ HIV/AIDS
☐ Cancer
☐ Other: _____

6. Check below if any of your family members have (or had):

☐ Heart problems / murmurs
☐ Seizures / epilepsy
☐ Kidney disease
☐ Hepatitis or liver disease
☐ HIV/AIDS

7. Did you receive a blood transfusion, blood products, or organ donation before 1992?

☐ Yes ☐ No

8. Did you receive clotting factors prior to 1987?

☐ Yes ☐ No

9. Check any of these that you now use, or that you have ever used:

☐ Cigarettes/tobacco/vaping	How often? _____	How much? _____
☐ Alcohol/beer/wine/liquor	How often? _____	How much? _____
☐ Marijuana	How often? _____	How much? _____
☐ Crack/cocaine	How often? _____	How much? _____
☐ Opioids (heroin/fentanyl)	How often? _____	How much? _____
☐ Suboxone/methadone	How often? _____	How much? _____
☐ Other: _____	How often? _____	How much? _____

LABEL

- CLINIC USE ONLY -

History reviewed by: _____ Date: _____

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