SEXUAL HEALTH HISTORY

INSTRUCTIONS: This form helps us to identify the appropriate testing options for you. Please complete this form (**alone**) and return it to the front desk. The nurse will discuss this form and follow-up questions with you during your visit.

SEXUAL HEALTH HISTORY

1. What brings you to the clinic today? *(check all that apply)*

- ☐ Screening/testing only (NO SYMPTOMS)
- ☐ I have symptoms that are bothering me
  Please describe your symptoms: _____
- ☐ I was told to come by a partner or someone else
  Who told you to come? _____
- ☐ My partner told me he/she has an STI
  Please specify which STI: _____
- ☐ Follow-up visit or treatment
- ☐ Other reason: _____

2. When was the last time you had sex (vaginal, anal, or oral) without a condom?
(Or when the condom broke or fell off during sex?) _____ / _____ / _____

3. How often do you use condoms?

☐ Never ☐ Sometimes ☐ Always ☐ Other: _____

4. How many sex partners have you had ... in the *last 2 months?* _____

... in the *last year?* _____

5. What types of sex have you had in the *last year*? *(check all that apply)*

- ☐ My mouth on my partner's (☐ vagina ☐ penis ☐ anus)
- ☐ My partner's mouth on my (☐ vagina ☐ penis ☐ anus)
- ☐ My vagina on my partner's (☐ vagina ☐ other: _____)
- ☐ My penis in/on my partner's (☐ vagina ☐ mouth ☐ anus)
- ☐ My partner's penis in/on my (☐ vagina ☐ mouth ☐ anus)
- ☐ Shared sex toys with my partner

6. Is your current sex partner with you today for their own visit? ☐ Yes ☐ No

7. Do you think (or know) that your partner has been having sex with someone else?

☐ Yes ☐ No ☐ Don't know

8. Are you or your partner currently using any method(s) to prevent pregnancy?

☐ Yes ☐ No ☐ Don't know

***If yes*, what method are you using?** _____

***If no*, would you like to discuss birth control options?** ☐ Yes ☐ No

FEMALES ONLY

9. Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know

10a. When was your last menstrual period? ____ / ____ / _____

10b. Was it a normal period for you? ☐ Yes ☐ No

11. Do you need a pregnancy test done today? ☐ Yes ☐ No

12. Do you need emergency contraception today?
(like the "morning after pill" or Plan B) ☐ Yes ☐ No ☐ Don't know

VISIT DATE:

- CLINIC USE ONLY -

LABEL

SEXUAL HEALTH HISTORY – CONTINUED

HEALTH SCREENING QUESTIONS

Please check all that apply for the following questions:	In the past year	In your lifetime	Never
13. Have you had sex with a male?	☐	☐	☐
14. Have you had sex with a female?	☐	☐	☐
15. Have you had sex with a transgender individual?	☐	☐	☐
16. Have you had sex with a man who has sex with other men?	☐	☐	☐
17. Have you had sex with someone who has HIV/AIDS?	☐	☐	☐
18. Have you had sex with someone who has hepatitis C?	☐	☐	☐
19. Have you had sex with strangers?	☐	☐	☐
20. Have you had sex for drugs, money, or other things you needed?	☐	☐	☐
21. Have you had sex with someone who exchanges sex for money, drugs, or other things they need?	☐	☐	☐
22. Have you used or shared equipment for injecting drugs, steroids, hormones, silicone, or other substances?	☐	☐	☐
23. Have you snorted or inhaled drugs?	☐	☐	☐
24. Have you gotten a tattoo or piercing outside of a licensed parlor?	☐	☐	☐
25. Have you lived with, or had sex with, someone who has hepatitis B?	☐	☐	☐
26. Have you stayed in jail or prison?	☐	☐	☐
27. Have you had a partner who hurt you in any way, including verbal or emotional abuse, threats, hitting, slapping, kicking or pushing you?	☐	☐	☐
28. Have you experienced unwanted sex or sexual acts?	☐	☐	☐

29. Have you had sex with someone you met through the internet or a mobile app?

☐ Yes ☐ No

If yes, which sites or apps have you used? _____

30. Have you been vaccinated for human papilloma virus (HPV), the virus that causes cervical cancer and genital warts?

☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure

32. Have you been vaccinated for hepatitis B (HBV)?

☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure

33. Have you been vaccinated for hepatitis A (HAV)?

☐ Yes ☐ No, but I would like to be ☐ No, I'm not interested ☐ Unsure

34. Are you interested in medication to prevent HIV (*i.e.* PrEP or PEP)?

☐ Yes ☐ No ☐ Unsure

35. Please list any specific questions you have for the provider today:

VISIT DATE:

- CLINIC USE ONLY -

LABEL

- CLINIC USE ONLY -

History reviewed by: _____ Date: _____

History reviewed by: _____ Date: _____