SEXUAL HEALTH HISTORY

Student Health Service

Name _____ Date _____

HISTORY								
Y	**N**		**Y**	**N**		**Y**	**N**	
☐	☐	Acne	☐	☐	Chlamydia	☐	☐	Hepatitis
☐	☐	Anemia	☐	☐	Genital Herpes	☐	☐	HIV
☐	☐	Blood Clots in legs/lungs	☐	☐	Genital Warts/HPV	☐	☐	Syphilis
☐	☐	Migraine Headaches	☐	☐	Gonorrhea	☐	☐	Have you been a victim of sexual assault

FAMILY HISTORY: Has anyone in your family had any of the following conditions?								
Y	**N**		**Y**	**N**		**Y**	**N**	
☐	☐	Blood Clots	☐	☐	Heart Attack	☐	☐	Stroke
☐	☐	Breast Cancer	☐	☐	Ovarian Cancer			

Provide medical, surgical, psychological or hospital stay update if applicable:

Do you? ☐ Drink Alcohol ☐ Smoke Tobacco ☐ Vape ☐ Use Drugs not prescribed for you

Your Sexuality	Your Gender	Your Pronouns
☐ Heterosexual or Straight	☐ Female	☐ She/Her/Hers
☐ Lesbian	☐ Male	☐ He/Him/His
☐ Gay	☐ Transgender MTF	☐ They/Them/Theirs
☐ Bisexual	☐ Transgender FTM	
☐ Asexual	☐ Gender Nonconforming	**Sexual anatomy at birth**
☐ Pansexual	☐ Genderqueer	☐ Female
☐ Queer	☐ Something else:	☐ Male
☐ Questioning		☐ Decline to answer
☐ Something else:		

Are you concerned about possible exposure to a sexually transmitted infection (STI)? ☐ Yes ☐ No

Do you have sex? ☐ Yes ☐ No Date of last sexual contact:

Types of sex: ☐ Oral ☐ Vaginal ☐ Anal

Total number of partners (life time): Your partners are: ☐ male ☐ female ☐ both

Do you use condoms/dental dams when you have sex? ☐ always ☐ sometimes ☐ never

Do you want an HIV test ordered? ☐ Yes ☐ No

Your health care provider is require to offer HIV testing to all persons between the ages of 13 and 64 regardless of apparent risk. You are encouraged to be tested if you have never been tested before.

For patients with FEMALE ANATOMY	
Do you get your period?	How many days does your period last?
Age when had first period:	Are your periods regular? ☐ Y ☐ N
How many days between periods?	Are your periods painful? ☐ Y ☐ N ☐ Sometimes
Date of Last Pap / Pelvic Exam:	Any vaginal discharge? ☐ Y ☐ N
Any bleeding or pain with intercourse? ☐ Y ☐ N	Any lumps or cysts in your breasts? ☐ Y ☐ N
Have you ever been pregnant? ☐ Y ☐ N	
Do you wish to continue your present method of birth control? ☐ Y ☐ N ☐ N/A	

CONTRACEPTION USED IN THE PAST TWO YEARS

Method	Date Started	Date Stopped	Reason Stopped

Any other concerns?

For patients with MALE ANATOMY
Any testicular or groin pain? ☐ Yes ☐ No
Any other concerns?