**Sexual Health Clinic**

**Client Health History**

Please complete this form as much as possible. All information is confidential.

### Todays’ Reason for Visit

- [ ] No symptoms or problems, I just want testing
- [ ] Call from Health Dept.
- [ ] I have an appointment
- [ ] Partner/Doctor told me to come
- [ ] Other (please explain):

### I have symptoms (check all that apply)

- [ ] Abnormal discharge
- [ ] Odor
- [ ] Itching
- [ ] Rash
- [ ] Burning when I pee
- [ ] Abdominal Pain
- [ ] Sores/bumps in genital area
- [ ] Swelling/pain in testicle(s)
- [ ] Other (please explain):

### PATIENT MEDICAL HISTORY

Have you ever been told by a doctor, nurse, or other health professional that you have:

<table>
<thead>
<tr>
<th>Condition</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
<th>[ ] Yes</th>
<th>[ ] No</th>
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</thead>
<tbody>
<tr>
<td>Diabetes? Check all that apply</td>
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<tr>
<td>Gestational Diabetes</td>
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<tr>
<td>Prediabetes</td>
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<tr>
<td>Borderline Diabetes</td>
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<td>Heart attack, angina coronary health disease or stroke?</td>
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<td>High blood pressure/or high cholesterol?</td>
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<td>Cancer?</td>
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<td>Mental Illness?</td>
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<td>Kidney Disease or Urinary Tract Infections?</td>
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<td>Seizures?</td>
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<td>Asthma, TB or Lung Problems?</td>
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<td>Hepatitis/Liver problems?</td>
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<tr>
<td>Other Chronic Health Problems:</td>
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</tbody>
</table>

**Hospitalizations:**

Prior sexually transmitted diseases (check all that apply):

- [ ] Chlamydia
- [ ] Gonorrhea
- [ ] Syphilis
- [ ] Trichomoniasis
- [ ] Herpes
- [ ] Genital Warts
- [ ] Hepatitis
- [ ] Pelvic inflammatory disease

Diagnosed with HIV?                          |        |        | IF yes, the date diagnosed: ____________
Diagnosed with AIDS?                         |        |        | IF yes, the date diagnosed: ____________
Do you see a doctor/provider?               |        |        |        |
Date last seen by provider: ________________ Where: ________________ Reason: ________________

Did you receive a flu vaccine this year?     |        |        | Other vaccines?

### Allergies (drugs/ others)?

- [ ] Yes
- [ ] No

If yes, list:

List all HIV medications ever taken:

List all other medications taken **in the past 2 weeks:**

**FEMALES ONLY:**

Date of last period: ______ Date of last Pap smear: ______ Pregnant? [ ] Yes [ ] No [ ] Unsure

Do you use birth control? [ ] Yes [ ] No

If yes, list:
**SOCIAL HISTORY**

Do you use tobacco products such as: (check box)

- ☐ Cigarettes
- ☐ Smokeless tobacco
- ☐ Electronic vapor product
- ☐ Hookah
- ☐ Pipe
- ☐ Chew

Do you: (check box)

- ☐ Drink alcohol
- ☐ Take street drugs
- ☐ Inject drugs
- ☐ Share needles/equipment

Are you experiencing domestic violence, sexual violence or human trafficking?

☐ Yes  ☐ No  If yes, would you like information or help today?  ☐ Yes  ☐ No

**SEXUAL HISTORY**

Have you traveled outside of the United States in the past 60 days?  ☐ Yes  ☐ No If yes, where?

<table>
<thead>
<tr>
<th># of sexual partners in the last 90 days</th>
<th># of sexual partners in the last 12 months</th>
<th># of sexual partners in your lifetime</th>
<th>When was the last time you had sex?</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ No</td>
<td>☐ Yes</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

In the last 12 months I have had sex with: (check all that apply)

- ☐ Women
- ☐ Men
- ☐ Transgender
- Date of last sexual activity: ____________________________

**In the last 12 months my sexual activities include:**

- Oral sex:
  - ☐ Give
  - ☐ Receive
  - ☐ None
  - If within last 3 months check here ☐

- Anal sex:
  - ☐ Give
  - ☐ Receive
  - ☐ None
  - If within last 3 months check here ☐

- Vaginal sex:
  - ☐ Give
  - ☐ Receive
  - ☐ None
  - If within last 3 months check here ☐

I use condoms for...

- ☐ Always
- ☐ Sometimes
- ☐ Never
- ☐ N/A

- Oral sex:
  - ☐ Always
  - ☐ Sometimes
  - ☐ Never
  - ☐ N/A

Exchanging sex for drugs, money or place to live?

- ☐ Yes
- ☐ No

Having sex while intoxicated or high on drugs?

- ☐ Yes
- ☐ No

Did any of your partners have an STD (including HIV)?

- ☐ Yes
- ☐ No
- ☐ Unsure

Was any of your partners that you had sex with: (check all that apply)

- ☐ HIV positive
- ☐ IV Drug User
- ☐ Exchanging sex for drugs/money

**FEMALES ONLY:**

I have had vaginal or anal (rectal) sex with a man who has sex with men  ☐ Yes  ☐ No  ☐ Unsure

**SIGNATURE**

I have answered all the questions correctly to the best of my knowledge.

___________________________________
Print Name of Client

___________________________________
Signature

______________
Date