

Sexual Health Clinic Client Health History

Label

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

Today's Reason for Visit	
<input type="checkbox"/> No symptoms or problems, I just want testing <input type="checkbox"/> Call from Health Dept. <input type="checkbox"/> I have an appointment <input type="checkbox"/> Partner/Doctor told me to come <input type="checkbox"/> Other (please explain):	<input type="checkbox"/> I have symptoms (check all that apply) <input type="checkbox"/> Abnormal discharge <input type="checkbox"/> Odor <input type="checkbox"/> Itching <input type="checkbox"/> Rash <input type="checkbox"/> Burning when I pee <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Sores/bumps in genital area <input type="checkbox"/> Swelling/pain in testicle(s) <input type="checkbox"/> Other (please explain):

PATIENT MEDICAL HISTORY		FAMILY HISTORY	If yes, list person
Have you ever been told by a doctor, nurse, or other health professional that you have:		(parents, sibling)?	
Diabetes? Check all that apply <input type="checkbox"/> Gestational Diabetes <input type="checkbox"/> Prediabetes <input type="checkbox"/> Borderline Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Heart attack, angina coronary health disease or stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
High blood pressure/or high cholesterol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Mental Illness?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Kidney Disease or Urinary Tract Infections?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Seizures?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma, TB or Lung Problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hepatitis/Liver problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other Chronic Health Problems:			
Hospitalizations:			
Prior sexually transmitted diseases (check all that apply): <input type="checkbox"/> Chlamydia <input type="checkbox"/> Gonorrhea <input type="checkbox"/> Syphilis <input type="checkbox"/> Trichomoniasis <input type="checkbox"/> Herpes <input type="checkbox"/> Genital Warts <input type="checkbox"/> Hepatitis <input type="checkbox"/> Pelvic inflammatory disease			
Diagnosed with HIV? <input type="checkbox"/> Yes <input type="checkbox"/> No IF yes, the date diagnosed: _____			
Diagnosed with AIDS? <input type="checkbox"/> Yes <input type="checkbox"/> No IF yes, the date diagnosed: _____			
Do you see a doctor/provider? <input type="checkbox"/> Never <input type="checkbox"/> Within past 6 months <input type="checkbox"/> More than year			
Date last seen by provider: _____ Where: _____ Reason: _____			
Did you receive a flu vaccine this year: <input type="checkbox"/> Yes <input type="checkbox"/> No Other vaccines?			
Allergies (drugs/ others)? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure			
Do you use birth control? <input type="checkbox"/> Yes <input type="checkbox"/> 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?** _____

# of sexual partners in the last 90 days _____	# of sexual partners in the last 12 months _____	# of sexual partners in your lifetime _____	When was the last time you had sex? _____
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In the last 12 months I have had sex with:(check all that apply)

Women Men Transgender Date of last sexual activity: _____

Steady partners (*people you regularly have sex with*) # of **different steady** partners last 3 mons. _____

Casual partners (*people that you don't have sex with very often*) # of **different casual** partners last 12 mons. _____

In the last 12 months my sexual activities include:

Oral sex	<input type="checkbox"/> Give	<input type="checkbox"/> Receive	<input type="checkbox"/> None	If within last 3 months check here <input type="checkbox"/>
Anal sex	<input type="checkbox"/> Give	<input type="checkbox"/> Receive	<input type="checkbox"/> None	If within last 3 months check here <input type="checkbox"/>
Vaginal sex	<input type="checkbox"/> Give	<input type="checkbox"/> Receive	<input type="checkbox"/> None	If within last 3 months check here <input type="checkbox"/>

I use condoms for... **vaginal sex** Always Sometimes Never N/A

I use condoms for... **anal (rectal) sex** Always Sometimes Never N/A

I use condoms for... **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
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