Sexual Health Clinic: Health History Form

All information is confidential

Patient Label

Your Primary Care Provider: _____ **Pharmacy**:_____

TODAY'S 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):

PAST MEDICAL HISTORY:		**FAMILY HISTORY (PARENTS and SIBLINGS only):**	
Diabetes, gestational diabetes, pre-diabetes?	☐ Yes ☐ No	Diabetes, gestational diabetes, pre-diabetes?	☐ Yes ☐ No Who?_____
Heart disease or heart attack	☐ Yes ☐ No	Heart disease or heart attack	☐ Yes ☐ No Who?_____
High blood pressure	☐ Yes ☐ No	High blood pressure	☐ Yes ☐ No Who?_____
High cholesterol	☐ Yes ☐ No	High cholesterol	☐ Yes ☐ No Who?_____
Stroke	☐ Yes ☐ No	Stroke	☐ Yes ☐ No Who?_____
Cancer	☐ Yes ☐ No	Cancer	☐ Yes ☐ No Who?_____
Mental illness	☐ Yes ☐ No	Mental illness	☐ Yes ☐ No Who?_____
Kidney disease	☐ Yes ☐ No	Kidney disease	☐ Yes ☐ No Who?_____
Seizures	☐ Yes ☐ No	Seizures	☐ Yes ☐ No Who?_____
Asthma	☐ Yes ☐ No	Asthma	☐ Yes ☐ No Who?_____
Tuberculosis or other lung problems	☐ Yes ☐ No	Tuberculosis or other lung problems	☐ Yes ☐ No Who?_____
Hepatitis A, B, or C	☐ Yes ☐ No	Hepatitis A, B, or C	☐ Yes ☐ No Who?_____
Liver disease	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No Who?_____
Other chronic health problems?			

Allergies (drugs/medications/others)? ☐ Yes ☐ No If yes, list:

Medications taken in the past 2 months:

PAST SURGICAL HISTORY:	**PAST HOSPITALIZATIONS:**

Have you been tested for sexually transmitted infections in the past? ☐ Yes ☐ No

If yes, when? _____

Prior sexually transmitted infections (check all that apply):

☐Chlamydia ☐Gonorrhea ☐Syphilis ☐Trichomoniasis ☐Herpes ☐Genital Warts

☐Pelvic inflammatory disease

Other genital or urinary infections (check all that apply): ☐ UTI ☐Bacterial vaginosis ☐ Yeast infections

Diagnosed with HIV? ☐ Yes ☐ No IF yes, date diagnosed: _____ Are you in care for HIV? ☐Yes ☐No

Diagnosed with AIDS? ☐ Yes ☐ No IF yes, date diagnosed: _____

PrEP (HIV prevention): Do you know about pre-exposure prophylaxis (PrEP) to prevent HIV? ☐ Yes ☐ No

Already on PrEP? ☐ Yes ☐ No If not on PrEP, do you want discuss PrEP? ☐ Yes ☐ No

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Vaccinations:

Received flu vaccine this year? ☐ Yes ☐ No Have you ever received meningitis vaccine? ☐ Yes ☐ No

Received HPV vaccine? ☐ Yes ☐ No Other vaccines? ☐ Yes ☐ No

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, including marijuana ☐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 History of sexual assault? ☐ Yes ☐ No

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

SEXUAL HISTORY

What sex were you assigned at birth?	What is your current gender identity?	
☐ Male	☐ Male	☐ Gender queer, neither exclusively male nor female
☐ Female	☐ Female	☐ Other, please specify: _____
	☐ Transgender male / Trans man	☐ Choose not to disclose
	☐ Transgender female / Trans woman	

In the past 12 months, I have had sex with:	# of sexual partners in the last 90 days: _____ # of sexual partners in the last 12 months: _____ # of lifetime partners: _____ When was the last time you had sex (oral, anal, or vaginal)? _____
☐ Men	
☐ Women	
☐ Transgender	
☐ Other, please specify:	

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… oral sex ☐ Always ☐ Sometimes ☐ Never ☐ N/A

I use condoms for… anal (rectal) sex ☐ Always ☐ Sometimes ☐ Never ☐ N/A

I use condoms for… vaginal 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

Were 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