FAIRFAX COUNTY HEALTH DEPARTMENT
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.

VISIT DATE:
CLINIC USE ONLY

BASIC INFORMATION

1. Preferred Name: ____

2. **Birth Sex** ________________________

3. What gender do you identify as?

☐ Man ☐ Woman ☐ Transgender (MtF) ☐ Transgender (FtM) ☐ Other: _________

Preferred pronouns:

☐ He/him/his ☐ She/her/hers ☐ They/them/theirs ☐ Other: _________

4. 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:

In Self	NO	YES	In Self	NO	YES
DISCHARGE	☐	☐	RASH	☐	☐
ITCHING	☐	☐	LESION/BUMP	☐	☐
ODOR	☐	☐	PAIN	☐	☐
			PAINFUL URINATION	☐	☐

☐ Who told you to come to clinic today:____

☐ My partner told me, he/she has an STI

Please specify which Sexually Transmitted Infection (STI): ___________________________

☐ Follow-up visit or treatment

☐ Other reason: ____

____

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

____

____

6. When was the last time you had sex (vaginal, anal, or oral)? date: _____/_____/_____

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

If yes, clinic number assigned to partner: ____________________

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 information about birth control options? ☐ Yes ☐ No

LABEL

Client's Name: ______________________________

Client's PIN: _______________________________

Date of Birth: ______________________________

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SEXUAL HEALTH HISTORY - CONTINUED			
FEMALES ONLY (questions 9 – 11)			
9. When was your last menstruation period?	☐ Don't Know	**Date last period started:** ____/____/____	
9b. Was it a normal period for you?	☐ Yes	☐ No	☐ Don't Know
9c. Are you currently pregnant?	☐ Yes	☐ No	☐ Don't Know
9d. Do you need a pregnancy test done today?	☐ Yes	☐ No	☐ Don't Know
10. Does your partner prevent you from using birth control when you want to use it?		☐ Yes	☐ No
11. Have you had a hysterectomy?		☐ Yes	☐ No

12. How many sex partners have you had…in the last month: ________________

in the last 3 months: ______________ **in the last year:** _______________

13. Sex partners: ☐ Female ☐ Male ☐ Both

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

☐ **My mouth on my partner's**	☐ **vagina**	☐ **penis**	☐ **anus**	**Protected: (check one)**	☐Never ☐Sometimes ☐Always
☐ **My partner's mouth on my**	☐ **vagina**	☐ **penis**	☐ **anus**	**Protected: (check one)**	☐Never ☐Sometimes ☐Always
☐ **My vagina on my partner's**	☐ **vagina**	☐ **penis**	☐ **other** ______	**Protected: (check one)**	☐Never ☐Sometimes ☐Always
☐ **My penis in/on my partners**	☐ **vagina**	☐ **penis**	☐ **anus**	**Protected: (check one)**	☐Never ☐Sometimes ☐Always
☐ **My partner's penis in/on my**	☐ **vagina**	☐ **penis**	☐ **anus**	**Protected: (check one)**	☐Never ☐Sometimes ☐Always
☐ **Shared sex toys with my partner**			☐ Yes	☐ No	

15. How often do you use condoms?

☐ Never ☐ Sometimes ☐ Always ☐ Other ______________

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SEXUAL HEALTH HISTORY - CONTINUED				
Please answer the following questions:	In the past year	In your lifetime	Never	Don't Know
16. Have you had sex with someone who has HIV/AIDS?	☐	☐	☐	☐
17. Have you had sex with strangers?	☐	☐	☐	☐

18. 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

19. Are you interested in medication to prevent HIV *(PrEP: Pre-Exposure Prophylaxis)*?

☐ Yes ☐ No ☐ Unsure

Please answer the following questions:	Frequently	Fairly Often	Some Times	Rarely	Never
20. How often does your partner physically H**urt you?**	☐	☐	☐	☐	☐
21. How often does your partner I**nsult or talk down to you?**	☐	☐	☐	☐	☐
22. How often does your partner T**hreaten you with physical harm?**	☐	☐	☐	☐	☐
23. How often does you partner S**cream or curse at you?**	☐	☐	☐	☐	☐

24. Have you experienced unwanted sex or sexual acts? ☐ Yes ☐ No

25. Does your partner prevent the use of condom when you want a condom to be used? ☐ Yes ☐ No

GENERAL HEALTH HISTORY

26. Check below if you or any of your family members have (or had):

	You	Family Member		You	Family Member
Heart problems/murmurs	☐	☐	Hepatitis or liver disease	☐	☐
Seizures/epilepsy	☐	☐	HIV/AIDS	☐	☐
Kidney Disease	☐	☐			

____ Date: ____________________

Signature of person completing this form

LABEL

Client's Name: ____________________________

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