VISIT HEALTH HISTORY

Instructions: Complete at each visit (except follow-up visits). **Date:** ___ / ___ / _______

SECTION 1. SEXUAL HEALTH	- OFFICE USE ONLY -
	Date and initial each entry

1. 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: ___________________________________
   - ☐ I was told to come by a partner or someone else
     Who told you to come? ___________________________________
   - ☐ My partner told me he/she has an STI
     Please specify which STI: ___________________________________
   - ☐ For birth control or family planning services
   - ☐ Follow-up visit or treatment
   - ☐ Other reason: _________________________________

2. When was the last time you had sex (vaginal, anal, and/or oral) without a condom? (Or when the condom broke or fell off during sex?) _____ / _____ / _______

3. How often do you use condoms?
   ☐ Never ☐ Sometimes ☐ Always ☐ Other: ______________

4. What types of sex have you had in the ***last year***? *(check all that apply)*
   - ☐ My mouth on my partner's (☐ vagina ☐ penis ☐ anus ☐ other: __________)
   - ☐ My partner's mouth on my (☐ vagina ☐ penis ☐ anus ☐ other: __________)
   - ☐ My vagina on my partner's (☐ vagina ☐ penis ☐ mouth ☐ other: _________)
   - ☐ My partner's vagina on my (☐ vagina ☐ penis ☐ mouth ☐ other: _________)
   - ☐ My penis in/on my partner's (☐ vagina ☐ mouth ☐ anus ☐ other: ________)
   - ☐ My partner's penis in/on my (☐ vagina ☐ mouth ☐ anus ☐ other: ________)
   - ☐ Shared sex toys with my partner

5. How many sex partners have you had ... in the ***last 2 months***? _________________
   … in the ***last year***? _________________

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

7. Are you or your partner currently using any method(s) to prevent pregnancy?
   ☐ Yes ☐ No ☐ Don't know ☐ Not applicable
   If yes, what method are you using? ____
   If no, would you like to discuss birth control options today? ☐ Yes ☐ No

SECTION 2. IF ASSIGNED FEMALE AT BIRTH	- OFFICE USE ONLY -
	Date and initial each entry

8. Are you currently pregnant? ☐ Yes ☐ No ☐ Don't know
9. Do you need emergency contraception today? *(like the "morning after pill" or Plan B)* ☐ Yes ☐ No ☐ Don't know

- OFFICE USE ONLY –
☐ *Interpreter or assistive services used* ☐ *Declined*
Name: _____________________________________
Title: ________________ Number: ___________

LABEL

Date: ___ / ___ / _______

SECTION 3. HEALTH SCREENING QUESTIONS				- OFFICE USE ONLY -
Please answer the following questions:	**In the past year**	**In your lifetime**	**Never**	*Date and initial each entry*
10. Have you had sex with a male?	☐	☐	☐	
11. Have you had sex with a female?	☐	☐	☐	
12. Have you had sex with a transgender individual?	☐	☐	☐	
13. Have you had sex with strangers?	☐	☐	☐	
14. Have you had sex with someone who has HIV/AIDS?	☐	☐	☐	
15. Have you had sex with a man who has sex with other men?	☐	☐	☐	
16. Have you had sex for drugs, money, or other things you needed?	☐	☐	☐	
17. Have you had sex with someone who exchanges sex for money, drugs, or other things they need?	☐	☐	☐	
18. Have you stayed in jail or prison?	☐	☐	☐	
19. Have you injected a drug not prescribed by a doctor?	☐	☐	☐	
20. Have you snorted drugs?	☐	☐	☐	
21. Have you shared equipment for injecting or inhaling drugs, steroids, hormones, silicone, or other substances?	☐	☐	☐	
22. Have you gotten a tattoo or piercing outside of a licensed parlor?	☐	☐	☐	
23. Have you had sex with someone who has hepatitis C?	☐	☐	☐	
24. Have you lived with, or had sex with, someone who has hepatitis B?	☐	☐	☐	
25. Have you been hit, slapped, choked, sexually abused, or otherwise physically hurt by anyone, including someone you were dating or going out with?	☐	☐	☐	
26. Has anyone made you have sex (vaginal, oral, or anal) when you didn't want to, including someone you were dating or going out with?	☐	☐	☐	

27. Have you had sex with someone you met through the internet or a mobile app?
☐ Yes ☐ No
If yes, which sites or apps have you used? ___________________________________

28. Do you think (or know) that your sex partner has been having sex with someone else?
☐ Yes ☐ No ☐ Don't know

29. Are you interested in medication to prevent HIV (*i.e.* PrEP or nPEP)?
☐ Yes ☐ No ☐ Unsure

30. Have you ever had a HIV test? ☐ No ☐ Yes: Date of last test? ______________

31. Have you ever had a syphilis test? ☐ No ☐ Yes: Date of last test? ______________

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

***Reminder**: Record any changes to the client's medical or STI history on the "General Health History" form.*

- OFFICE USE ONLY -		
REVIEW NOTES	***INITIALS***	***DATE***
☐ *Reviewed, no changes* ☐ *Reviewed, changes as noted*		
☐ *Reviewed, no changes* ☐ *Reviewed, changes as noted*		

LABEL