

VISIT HEALTH HISTORY

Instructions: Complete at each visit (except follow-up visits).

Date: ___ / ___ / _____

SECTION 1. SEXUAL HEALTH	- OFFICE USE ONLY -
<p>1. What brings you to the clinic today? <i>(check all that apply)</i></p> <p><input type="checkbox"/> Screening/testing only (NO SYMPTOMS)</p> <p><input type="checkbox"/> I have symptoms that are bothering me Please describe your symptoms: _____</p> <p><input type="checkbox"/> I was told to come by a partner or someone else Who told you to come? _____</p> <p><input type="checkbox"/> My partner told me he/she has an STI Please specify which STI: _____</p> <p><input type="checkbox"/> For birth control or family planning services</p> <p><input type="checkbox"/> Follow-up visit or treatment</p> <p><input type="checkbox"/> Other reason: _____</p> <p>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?) _____ / _____ / _____</p> <p>3. How often do you use condoms? <input type="checkbox"/> Never <input type="checkbox"/> Sometimes <input type="checkbox"/> Always <input type="checkbox"/> Other: _____</p> <p>4. What types of sex have you had in the last year? <i>(check all that apply)</i></p> <p><input type="checkbox"/> My mouth on my partner's (<input type="checkbox"/> vagina <input type="checkbox"/> penis <input type="checkbox"/> anus <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> My partner's mouth on my (<input type="checkbox"/> vagina <input type="checkbox"/> penis <input type="checkbox"/> anus <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> My vagina on my partner's (<input type="checkbox"/> vagina <input type="checkbox"/> penis <input type="checkbox"/> mouth <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> My partner's vagina on my (<input type="checkbox"/> vagina <input type="checkbox"/> penis <input type="checkbox"/> mouth <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> My penis in/on my partner's (<input type="checkbox"/> vagina <input type="checkbox"/> mouth <input type="checkbox"/> anus <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> My partner's penis in/on my (<input type="checkbox"/> vagina <input type="checkbox"/> mouth <input type="checkbox"/> anus <input type="checkbox"/> other: _____)</p> <p><input type="checkbox"/> Shared sex toys with my partner</p> <p>5. How many sex partners have you had ... in the last 2 months? _____ ... in the last year? _____</p> <p>6. Is your current sex partner with you today for their own visit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>7. Are you or your partner currently using any method(s) to prevent pregnancy? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know <input type="checkbox"/> Not applicable</p> <p>If yes, what method are you using? _____</p> <p>If no, would you like to discuss birth control options today? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>Date and initial each entry</p>

SECTION 2. IF ASSIGNED FEMALE AT BIRTH	- OFFICE USE ONLY -
<p>8. Are you currently pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p> <p>9. Do you need emergency contraception today? <i>(like the "morning after pill" or Plan B)</i> <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know</p>	<p>Date and initial each entry</p>

- OFFICE USE ONLY -
<p><input type="checkbox"/> Interpreter or assistive services used <input type="checkbox"/> Declined</p> <p>Name: _____</p> <p>Title: _____ Number: _____</p>

LABEL

SECTION 3. HEALTH SCREENING QUESTIONS				- OFFICE USE ONLY -
Please answer the following questions:	In the	In your	Never	Date and initial each entry
	past year	lifetime		
10. Have you had sex with a male?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
11. Have you had sex with a female?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
12. Have you had sex with a transgender individual?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
13. Have you had sex with strangers?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
14. Have you had sex with someone who has HIV/AIDS?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
15. Have you had sex with a man who has sex with other men?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
16. Have you had sex for drugs, money, or other things you needed?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
17. Have you had sex with someone who exchanges sex for money, drugs, or other things they need?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
18. Have you stayed in jail or prison?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
19. Have you injected a drug not prescribed by a doctor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
20. Have you snorted drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
21. Have you shared equipment for injecting or inhaling drugs, steroids, hormones, silicone, or other substances?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
22. Have you gotten a tattoo or piercing outside of a licensed parlor?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
23. Have you had sex with someone who has hepatitis C?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
24. Have you lived with, or had sex with, someone who has hepatitis B?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
25. Have you been hit, slapped, choked, sexually abused, or otherwise physically hurt by anyone, including someone you were dating or going out with?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
27. Have you had sex with someone you met through the internet or a mobile app? <input type="checkbox"/> Yes <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know				
29. Are you interested in medication to prevent HIV (i.e. PrEP or nPEP)? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unsure				
30. Have you ever had a HIV test? <input type="checkbox"/> No <input type="checkbox"/> Yes: Date of last test? _____				
31. Have you ever had a syphilis test? <input type="checkbox"/> No <input type="checkbox"/> 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
<input type="checkbox"/> Reviewed, no changes		
<input type="checkbox"/> Reviewed, changes as noted		
<input type="checkbox"/> Reviewed, no changes		
<input type="checkbox"/> Reviewed, changes as noted		

LABEL
