COLUMBUS STATE UNIVERSITY STUDENT HEALTH CENTER

NAME:______________________________ **D.O.B:**____________ **DATE:**______________

SEXUAL HISTORY

Do you have any history of sexual or physical abuse? Yes No

Have you ever been sexually active? Yes No

Are you currently sexually active? Yes No

Are your sexual partners: Men Women Both

How many sex partners have you had in the last: Month:______ 6 months:_______ Lifetime total partners:________

Is your current sexual partner your only sex partner? Yes No

Have any of your sex partners had other sex partners? Yes No Do not know

When was your last sexual encounter? ______________________________

What kind of sexual contact have you had? Vaginal Oral Anal

If <u>oral</u> do you: Give Receive Both If <u>anal</u> do you: Give Receive Both

Do you use condoms or other protection when having sex? Yes No

If y<u>es</u>, how often do you use protection? Always Sometimes

Do you ever experience pain during sexual intercourse? Yes No

Have you ever been tested for HIV? Yes No If **yes** when:______________________________

If **not**, would you like to be tested? Yes No

Have you ever had any sexually related diseases? Yes No

If **yes**, what was the name of the infection?____________________Date of infection?____________________

Did you receive treatment? Yes No

If **yes**, did you complete the full course of treatment? Yes No

Did your symptoms return after treatment? Yes No

Are you experiencing any symptoms now? Yes No

If **so**, what are they?____

Has your partner ever been treated for a sexually transmitted disease? Yes No Unsure

If **yes**, name of infection____

Does your partner have symptoms now? Yes No Unsure

Do you or your partner (s) use alcohol? Yes No

Do your or your partner(s) use Drugs? Yes No

For Females: Is there a possibility that you are pregnant? Yes No 1st Day of Last Menstrual Period___________

Have you ever had:Bacterial Vaginitis Yeast Infection Pelvic Inflammatory Disease None of these