Columbus State University Student Health Services – Sexual History

Date: _____

Name: _____ 909 _____

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

Have you ever been sexually active? Yes ☐ No ☐

Your sex partners are: Men ☐ Women ☐ Both ☐

Number of sex partners**: in the last month**: _____ **in the last 6 months**: _____

When was your last sexual encounter? _____

Last encounter was with: Male ☐ Female ☐

What type of sex have you had? Vaginal ☐ Oral ☐ Anal ☐

If Oral, Do you: Give ☐ Receive ☐ Both ☐

If Anal, Do you: Give ☐ Receive ☐ Both ☐

Do you use condoms or other protection when having sex? Never ☐ Sometimes ☐ Always ☐

Have you ever had a Sexually Transmitted Infection? Yes ☐ No ☐

Date/s of infection: _____

Name of the infection/s _____

If you are you experiencing any symptoms now, what are they? _____

Have any of your **partners** ever had a Sexually Transmitted Infection? Yes ☐ No ☐ Unsure ☐

If yes, name of the infection? _____

_____

Would you be interested in a free HIV test? Yes ☐ No ☐

Do you have a history of HIV? Yes ☐ No ☐

Are you currently taking PrEP? Yes ☐ No ☐

<u>For Females</u>:

What is the **1st Day** of your **last period**? _____

Have you ever been pregnant? Yes ☐ No ☐

Have you taken Plan B? Yes ☐ No ☐ **If yes,** date that you took it: _____

Have you ever had: Yeast Infection ☐ Bacterial Vaginitis ☐ Pelvic Inflammatory Disease ☐

None of these ☐

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