UMW SHC Sexual Health History

Name: _____ Date: _____

Please circle and answer all that apply:

1. Is there a specific encounter that you are concerned about? **Yes -- No**

2. You have (have had) _____ sexual partner. **More than one -- One**

3. Do you use any form of birth control? **Yes with _____ -- No**

4. Do you have sex without condoms _____. **Often -- Sometimes -- Never**

5. What kind of sexual contacts did you have?

Oral (mouth on genitals/anus) -- Vaginal (penis or object in vagina)

Anal (penis or object in anus) -- Objects (oral, vaginal, anal) -- Other types of sex

6. Have you had a history of sexually transmitted infection (STI like chlamydia, gonorrhea, genital warts, HIV, syphilis, Trichomonas) **Yes -- No**

7. When were you last tested? _____ What was tested? _____

8. Have you or your partner ever injected Drugs? **Yes -- No**

9. Have you experienced physical, emotional, or sexual violence from a partner?

Yes -- No

10. Do you have any concerns about your sex life? _____

_____

11. Are you interested in learning about _____.

Birth Control - Ways to prevent HIV and other STI's - Not interested