

Instant Sexual History

Disease	Are you being treated for? (medications?)	Have you ever had? (date(s) tested positive?)
Chlamydia Trachomatis		
Gonorrhea		
Trichomoniasis		
Hepatitis B		
Hepatitis C		
Genital Herpes		
Syphilis		
HPV/Genital Warts		
HIV		
Lymphogranuloma Venereum		
Pelvic Inflammatory Disease		
Other		

Check if yes

- Ever used illegal drugs?
- Ever used IV or intranasal drugs?
- Ever shared needles or other drug paraphernalia?
- Had sex while under the influence of drugs/alcohol in the last month?
- Do you use sex toys?
- Ever had an anonymous partner?
- Ever paid for sex?
- Commercial sex worker?
- Had sex with an HIV positive individual in the last 12 months?
- Forced sex?
- Traded sex for money or drugs in the last 12 months?
- Had more than one sex partner in the last 12 months?

Last sexual encounter: ___/___/___

Sexual practices: oral anal genital

Sexual preferences: male female both

Number of partners in last 3 months: _____males _____females

Any pregnant partners? yes no

Condom use: always usually sometimes never

Last tested for HIV: ___/___/___

Females only:

Currently pregnant? yes no

EDC? ___/___/___

Breastfeeding? yes no

Using contraceptives? yes no If yes, type: _____

If testing will be performed today:

Urinated in the last hour? yes no

Anything in your vagina in the last 3 days? yes no