

Personal Medical/Sexual and Social History

Name: _____ Birthdate: _____

Gender Identity: _____ Social Security #: _____

Sex assigned at birth (check one): Male Female

Please tell us why you are here today: _____

****All responses are confidential

Medication List: (Include all prescribed or over-the-counter medications, supplements, vitamins, etc.)

Name	Dose	How Often?	Why Taken?

Allergies	Reaction

Current or Past Medical History/Health Problems (List all): _____

Surgery or Procedures (List with dates): _____

Sexual History (Please check/complete all that apply)

Are your sex partners: Men Women Both

Sex practices: Oral (mouth to penis/vagina/anus) Vaginal (Penis to Vagina) Anal (Penis to Anus)

Number of sex partners: Last 3 months: _____ Last 12 months: _____ Lifetime: _____

When was the last time you had sex? _____

Do you use a condom or other barrier to protect against STIs: Always Sometimes Never

History of STIs: Herpes Chlamydia Gonorrhea HIV/AIDS HPV/Genital Warts
 Syphilis Trichomonas Hepatitis B Hepatitis C Other: _____

Have you had the HPV vaccine/shot (Gardasil)? Yes No Unknown

Have you had an HIV test before? Yes No If yes, when? _____

(CONTINUED ON BACK)

Personal Medical/Sexual and Social History

Social History (Please check/complete all that apply)

Do you smoke cigarettes? Yes No If yes, how many per day? _____

Do you vape/Juul? Yes No

Do you use smokeless tobacco? Yes No

Do you drink alcohol (beer, wine, liquor)? Yes No If yes, how many drinks per day? _____

If yes, how many drinks per week? _____

Have you ever used drugs, marijuana or prescription drugs not prescribed to you? Yes No

If yes, type: _____ Last Use: _____

Current or past injection drug use? Yes No Shared Needles? Yes No

Have you ever had a sex partner that used injection drugs? Yes No

Have you ever been in jail/prison? Yes No

Do you feel safe going home today? Yes No

Does your partner ever make you feel afraid? Yes No

Has anyone ever hit you, hurt you or threatened you? Yes No

Has anyone ever forced you to have sex or do something sexually that you didn't want to do? Yes No

Have you ever had sex for money, drugs, or something else that you needed (clothes, food, housing)? Yes No

FEMALE Patients

Are you currently using birth control for prevention of pregnancy? Yes No

If yes, what method? _____

Are you seeking pregnancy? Yes No

First day of last menstrual period (LMP)? _____

Test Results

Results are typically received within 5 business days. Initially results will not be mailed, and results will never be left on voicemail. Check below regarding how you would like to be notified of your results.

"No news is good news." If everything is negative, I will not receive a phone call.

Phone call to this number: _____. It is okay to leave a message to call back if I do not answer. Results **WILL NOT** be left, only a message to call us back.

Phone call to this number: _____. Do not leave any message. I will call back when I see that you have called.

***Please be advised that a certified letter will be mailed after 14 days if no response to positive results.**