

TOBACCO USE:

Have you ever smoked cigarettes? YES NO If yes, are you a current smoker former smoker

If current smoker:

- How often do you smoke cigarettes? every day some days, but not every day
- How many cigarettes a day do you smoke? 5 or less 6-10 11-20 21-20 31 or more
- How soon after you wake up do you smoke your first cigarette? within 5 min 6-30 min 31-60 min after 60 min
- Are you interested in quitting? ready to quit thinking about quitting not ready to quit

If former smoker: How long has it been since you last smoked?

<1 month 1-3 months 3-6 months 6-12 months 1-5 years 5-10 years >10 years

ALCOHOL USE: Do you drink alcohol? NO occasionally every day

DRUG USE: Marijuana use: YES NO If yes, occasionally regularly

Have you ever used intravenous drugs? YES NO Have you ever had a sexual partner who used intravenous drugs? YES NO

SEXUAL HISTORY:

At what age did you first engage in sexual activity? _____ never been sexually active

Have you engaged in sexual activity in the past six months? YES NO

If yes: Are you sexually active with (check all that apply) men women transgender individuals

How many sexual partners do you currently have? _____

How many sexual partners have you had within the past six months? _____ In your lifetime? _____

Do you use condoms to protect yourself against HIV or other sexually transmitted infections? YES NO sometimes

RELATIONSHIP HISTORY: Did you know that your relationship affects your health? That's why we ask everyone about their relationships.

In the past year: (Circle one answer for each statement)

My partner refuses to use a condom:
Never, Rarely, Sometimes, Often, Always, N/A

My partner threatened or frightened me:
Never, Rarely, Sometimes, Often, Always

My partner messes with my birth control or tries to get me pregnant when I don't want to be:
Never, Rarely, Sometimes, Often, Always, N/A

My partner hit, slapped, or physically hurt me:
Never, Rarely, Sometimes, Often, Always

My partner made me have sex when I didn't want to:
Never, Rarely, Sometimes, Often, Always

Ever:
Has anyone forced you into a sexual act ever in your lifetime?
 YES NO

GYN HISTORY:

How old were you when you had your first menstrual period? _____

Have you had any bleeding or spotting since your last period? YES NO If yes, when? _____

Do you get your period every 21-35 days? YES NO

How many days do you bleed? _____ Is the bleeding mild moderate heavy

PAP HISTORY:

Have you ever had a Pap test? (Test for cervical cancer) YES NO When was the last time you had one? _____

What were the results? _____ Any treatment? Colposcopy Cryotherapy LEEP Other _____

Did your mother take DES when she was pregnant with you? YES NO DON'T KNOW

Have you ever had a sexually transmitted infection (STI)? YES NO If yes, which one(s):
 Chlamydia Gonorrhea Trichomoniasis Syphilis Herpes HIV Other: _____

Have you ever had a sexual partner who had a sexually transmitted infection (STI)? YES NO

If yes, which STI(s)? _____

Have you ever used birth control? YES NO

Which method(s)? condoms pills NuvaRing Ortho Evra patch Depo-Provera
 contraceptive sponge diaphragm IUD Norplant Implanon Other _____

Have you had problems with any of these? YES NO If yes, what problems? _____

What are you currently using to prevent pregnancy? _____

OB HISTORY:

Do you have children? YES NO If yes, how many? _____

How many times have you been pregnant? (Including today) _____ Number of C-sections _____ DATES _____

Number of live births _____ DATES _____

Number of miscarriages _____ DATES _____

Number of abortions _____ Approximate date or year _____ (Not including today)

Number of tubal (ectopic) pregnancies _____ DATES _____

Have you ever had a problem with a delivery or an abortion? YES NO If yes, please explain _____

Are you currently breastfeeding? YES NO

HIV TESTING:

Have you ever had an HIV test? YES NO If yes, when was the most recent test? _____

Would you like to be tested for HIV today? YES NO