



**GENITAL / SEXUAL HISTORY**

Age at first intercourse \_\_\_\_\_

Sexual Partner(s)    Male    Female    Both

**Yes No**

- Have you had an injury to your testicles / groin?
- Have you ever had a hernia?
- Had any problems with your scrotum (hydrocele / varicocele)?
- Had more than 1 sex partner in past year or a new partner?
- Had 5 or more sexual partners in lifetime?
- Do you use condoms with sex every time?
- Do you have any Questions/concerns about sex?
- Do you want testing for Sexually Transmitted Infections (STIs)
- Do you ever use your mouth to have sex?
- Do you ever use your rectum to have sex?
- Has a sex partner recently been diagnosed or treated for a STI?  
Date \_\_\_\_\_ Type of infection \_\_\_\_\_
- Is a sex partner having any symptoms of a STI now?  
Type of symptoms \_\_\_\_\_
- Have you ever caused a pregnancy?
- Have you fathered any children with genetic or birth defects?

**Have you ever had the following?**    No   If yes, check below:

- HPV/Warts    Herpes    Trichomonas
- Chlamydia    HIV / AIDS    Molluscum
- Gonorrhea    Syphilis    Bacterial vaginosis (BV)

**SOCIAL HISTORY / HEALTH HABITS**

**Yes No**

- Do you drink Alcohol? #\_\_\_ drinks per week
- Do you Smoke? #\_\_\_ cigarettes per day
- Do you take Street drugs? What? \_\_\_\_\_
- Do you perform testicular self-exam? (Examine your testicles)
- Want information to get help for alcohol/drug use?
- Been hit, hurt or made to feel afraid by an intimate partner, now or in the past?
- Been a victim of sexual abuse or coercion?

***I acknowledge that the above information is correct & complete. I understand that if any reportable disease is found it will be reported to the Health Department.***

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_

**Patient Name**

**Acct #**

**Date of Birth**

**STAFF NOTES**

- Emergency instructions given (Form #115)
- Teen counseling provided (if < age 18). Parental involvement \_\_\_\_\_
- STI/Safer Sex/condom info discussed
- Form #5: Medical consent /HIPAA Acknowledgement complete
- Pt refuses exam. Form 644 given/explained. Exam encouraged to R/O other STIs.

**Staff Signature** \_\_\_\_\_ **Title** \_\_\_\_\_

**Date** \_\_\_\_\_

***This Health History information, as supplied by the patient, was reviewed & verified by:***

**Clinician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Clinician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_

**Clinician Signature** \_\_\_\_\_ **Date** \_\_\_\_\_