

Name _____ Date _____

VACCINES

These vaccines are a series of 3 shots, check how many of the shots you have received:

Hepatitis B 1 shot 2 shots 3 shots

HPV (Gardasil or Cervarix) 1 shot 2 shots 3 shots

BIRTH CONTROL

Are you (or your partner) using a birth control method now (including condoms)? No Yes

If Yes, what method: _____

Are you having problems with your current method? No Yes

If Yes, what problem: _____

SEXUAL HISTORY

These questions may seem personal, but they help us to evaluate your health. All information is confidential.

Age at first intercourse: _____ Never had intercourse

How many sexual partners have you had in the last year? _____

Have you had a new partner in the past year? No Yes

If Yes, new partner in the last 60 days? No Yes

My partner(s) are: Women only Men only Both

Does your partner have sex with:
 Men only Women only Both I don't know

My partner is monogamous (only has sex with you):
 No Yes I don't know

Is your sexual contact (✓all that apply):
 Vaginal Anal Oral None Other _____

Do you use condoms? Always Sometimes Never

Did you use a condom the last time you had sex? No Yes

My partner has a sexually transmitted infection (STD):
 No Yes I don't know

My partner had symptoms of an STD in the last 60 days:
 No Yes I don't know

Have you ever shared needles (tattoo, piercings, IV drug use, etc.)? No Yes

My partner uses IV drugs: No Yes

Did you have a blood transfusion before 1985? No Yes

SUBSTANCE USE

Have you ever used street, recreational or IV drugs? If Yes, what? _____ No Yes

Do you currently use street, recreational or IV drugs? If Yes, what? _____ No Yes

Do you use tobacco?
What type of tobacco? _____ No Yes
How much per day? _____
For how many years? _____

Do you drink alcohol? No Yes
How much per day/week? _____

Do you feel you have a problem with drugs or alcohol? No Yes

If Yes, why? _____

LIFESTYLE/CHALLENGES/SUPPORT

Do you have any concerns about your weight or eating habits?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you have a healthy diet?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you being abused sexually, physically, or emotionally?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you exercise regularly?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Are you being forced to or talked in to doing something against your will?	<input type="checkbox"/> No <input type="checkbox"/> Yes	Do you work?	<input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have someone in your life you go to for support?	<input type="checkbox"/> No <input type="checkbox"/> Yes	If yes:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time <input type="checkbox"/> Student <input type="checkbox"/> Other
If Yes, who: _____			

ARE YOU HAVING THESE SYMPTOMS NOW OR DO YOU HAVE THEM VERY OFTEN?

<input type="checkbox"/> No <input type="checkbox"/> Yes	Big change in your weight (more than 25 pounds)	<input type="checkbox"/> No <input type="checkbox"/> Yes	Feeling depressed
<input type="checkbox"/> No <input type="checkbox"/> Yes	Fevers, chills, night sweats, or fatigue	<input type="checkbox"/> No <input type="checkbox"/> Yes	Having thoughts of suicide If YES, are you seeing a therapist? <input type="checkbox"/> No <input type="checkbox"/> Yes
<input type="checkbox"/> No <input type="checkbox"/> Yes	Breathing problems, coughing, or shortness of breath	<input type="checkbox"/> No <input type="checkbox"/> Yes	Problems or pain with urination (when you pee)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Chest pain	<input type="checkbox"/> No <input type="checkbox"/> Yes	Discharge from the penis
<input type="checkbox"/> No <input type="checkbox"/> Yes	Heart palpitations	<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain in your groin or testicles
<input type="checkbox"/> No <input type="checkbox"/> Yes	Fainting or passing out	<input type="checkbox"/> No <input type="checkbox"/> Yes	Rashes, sores or abnormal bumps on your skin
<input type="checkbox"/> No <input type="checkbox"/> Yes	Pain in your abdomen (belly), constipation, diarrhea, or vomiting	<input type="checkbox"/> No <input type="checkbox"/> Yes	Dizziness, really bad headaches, changes in your vision
<input type="checkbox"/> No <input type="checkbox"/> Yes	Bleeding from your rectum	<input type="checkbox"/> No <input type="checkbox"/> Yes	Intolerance to heat or cold (more than normal)
<input type="checkbox"/> No <input type="checkbox"/> Yes	Very little interest in activities you used to enjoy	<input type="checkbox"/> No <input type="checkbox"/> Yes	Excessive hunger or thirst (more than normal)