Planned Parenthood®
Care. No matter what.

Date: _____ Name:_____ DOB: _____

1. Do you have any of the following symptoms currently (please check all that apply):
☐Abnormal discharge from the vagina or penis ☐Painful urination ☐Pain with sex
☐Genital sores or bumps ☐Pelvic pain ☐Bleeding with sex

2. Have you ever been tested for HIV? ☐ yes ☐ no
If yes, when was your most recent test? _____

3. How many sex partners have you had within the last 12 months? _____

4. Do you have sex with: ☐ men ☐ women ☐ both

5. Do you use condoms? ☐ always ☐ sometimes ☐ never

6. Do any of your partners have a STI? ☐ yes ☐ no If yes, what:_____

7. Do your sex partners have sex with: ☐ men ☐ women ☐ both ☐unknown

8. In the past 12 months have you had (please check all that apply):
☐ oral (given) ☐ oral (received) ☐ vaginal ☐ anal (given) ☐ anal (received)

9. Is it possible that any of your sex partners in the past 12 months had sex with someone else while they were still having sex with you? ☐ yes ☐ no

10. Any new sex partners within the past three months? ☐ yes ☐ no

11. Have you recently been exposed to a STI? ☐ yes ☐ no

12. Have you ever had a STI? ☐ yes ☐ no
If yes, what?_____

13. Have any of your partners had symptoms of a STI in the past 60 days? ☐ yes ☐ no

14. Do any of your partners use IV drugs? ☐ yes ☐ no

15. Are you exposed to blood and/or body fluids at work? ☐ yes ☐ no

16. Have you ever shared needles with anyone? ☐ yes ☐ no

17. Do you have allergies to any medications or latex? ☐ yes ☐ no
If yes, what?_____

18. **For females only:**
What was the first day of your last period? _____

Any unprotected sex after your last period? ☐ yes ☐ no When?_____

Are you using a birth control method currently? ☐ yes ☐ no What?_____

Are you interested in discussing birth control options today? ☐ yes ☐ no