SEXUAL HISTORY DISCUSSION FORM

As part of the Syphilis Elimination Effort (SEE), this form will help you assess your patient's risks for syphilis and other sexually transmitted diseases (STDs), while providing parameters for discussion of sexual health issues. A sexual history needs to be taken during a patient's initial visit, during routine preventive exams, and when you see signs of an STD. This form is meant to provide you with a sample of discussion points; it is not a standard for diagnosis or a complete reference for sexual history taking. It may need to be modified to be culturally appropriate or to respond to a patient's sexual orientation. Some patients may not be comfortable talking about sexual matters. Letting them know that this is an important part of a regular medical exam or physical history will help to put them at ease.

1. Partners

For sexual risk, one of the most important areas to determine is the *number* and *gender* of your patient's sex partners. Never make assumptions.

_____ Use of condoms

_____ Other risk factors (e.g. alcohol & drug use)

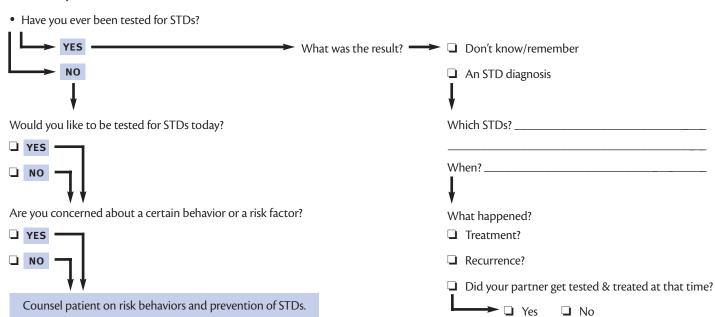
2. Practices & Protection from STDs

Asking about other sex practices will guide risk-reduction strategies and identify anatomical sites from which to collect specimens for syphilis, HIV, and other STD testing.

• What kind of sexual contact do you have or have you had?

Have Sexual Contact	Currently	In the Past	Condom Use:	Always	Sometimes	Never
Genital (penis in vagina)						
Anal						
Oral						

3. Past History of STDs



3. Past History of STDs	(cont.)			
Has your current p YES	artner or have any of your previous partners ever been diag	Which STDs?		
NO NO		When?		
Do you think they'd like to be tested?		♥ What happened?		
YES T	Provide referral information or tell your patient	☐ Treatment?		
	to bring his or her partner to your office.	☐ Recurrence?		
□ NO		☐ Did you get tested & treated at that time?		
Counsel patient on risk behaviors and prevention of STDs.		¥ Yes □ No		
		Would you like to be tested for STDs today?☐ Yes		
		□ No		
4. Protection from Pre	gnancy			
Are you currently t	rying to conceive or father a child?			
YES				
NO —		What type(s) of birth control measures are you using?		
		. ↓		
		Do you need more information about birth control?		

• Are there any other topics you would like to discuss pertaining to your sexual health?





☐ Yes☐ No