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.**

- How many sex partners have you had in the past 12 months?

→ **NONE** (GO TO QUESTION #2)

It is still important to take a sexual history when a patient reports no sexual activity within the last 12 months but indicates sexual activity in the past.

→ **ONE** → Your Partner's
(a) Gender _____
(b) Drug use _____
(c) Other sex partners _____
(d) Length of relationship _____

→ **MORE THAN ONE** →
_____ Number of partners
_____ Gender of partners
_____ 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

- Have you ever been tested for STDs?

→ **YES** → What was the result? →
❑ Don't know/remember
❑ An STD diagnosis

→ **NO**

Would you like to be tested for STDs today?

❑ **YES**
❑ **NO**

Are you concerned about a certain behavior or a risk factor?

❑ **YES**
❑ **NO**

Counsel patient on risk behaviors and prevention of STDs.

Which STDs? _____
_____
When? _____

What happened?
❑ Treatment?
❑ Recurrence?
❑ Did your partner get tested & treated at that time?
→ ❑ Yes ❑ No

3. Past History of STDs *(cont.)*

- Has your current partner or have any of your previous partners ever been diagnosed or treated for an STD?

YES → Which STDs? _____

_____

When? _____

NO

Do you think they'd like to be tested?

❑ YES → Provide referral information or tell your patient to bring his or her partner to your office.

❑ NO

Counsel patient on risk behaviors and prevention of STDs.

What happened?

❑ Treatment?

❑ Recurrence?

❑ Did you get tested & treated at that time?

❑ Yes

❑ No

Would you like to be tested for STDs today?

❑ Yes

❑ No

4. Protection from Pregnancy

- Are you currently trying 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?

❑ Yes

❑ No

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