♀ Allentown Women's Center

Sexual History

Legal Name: _____ DOB: _____

Preferred Name: _____ Pronouns: _____

Date of Visit: _____

Partners

Have you been sexually active in the last year? ❑ Yes ❑ No

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

Practices

Protection from STI's

In the past year, have you given or received vaginal sex? ❑ Yes ❑ No

Do you use condoms when you have vaginal sex? ❑ Always ❑ Sometimes ❑ Never

In the past year, have you given or received oral sex? ❑ Yes ❑ No

Do you use condoms/dental dams when you have oral sex? ❑ Always ❑ Sometimes ❑ Never

In the past year, have you given or received anal sex? ❑ Yes ❑ No

Do you use condoms when you have anal sex? ❑ Always ❑ Sometimes ❑ Never

Identifying Risk

Have you or any of your partners ever injected drugs into their bodies? ❑ Yes ❑ No

Do you use alcohol or drugs when you have sex? ❑ Yes ❑ No

Do(es) your partner(s) use alcohol or drugs when you have sex? ❑ Yes ❑ No

Have you or any of your partners ever received or given money, shelter, or drugs in exchange for sex? ❑ Yes ❑ No

Have you or any of your partners ever been incarcerated? ❑ Yes ❑ No

Do(es) your partner(s) ever make you have sex when you don't want to? ❑ Yes ❑ No

Do(es) your partner(s) ever tamper with your birth control or refuse to use protection when asked? ❑ Yes ❑ No

Pregnancy Plans

Do you have plans/desires to have (more) children? ❑ Yes ❑ No

Do you have any need for contraception/birth control? ❑ Yes ❑ No

Please continue onto the back ➔ ➔ ➔

Past History of STI's

Have you ever had a sexually transmitted infection? ❑ Yes ❑ No

If yes:

What kind have you had? _____

_____

When did you have it? _____

_____

How were you treated/what medications did you take? _____

_____

Have you noticed any symptoms (ex: burning, itching, sores, dripping) since treatment? ❑ Yes ❑ No

If yes, explain: _____

_____

Sexual Health & Function

Have you had any changes in sexual desire or satisfaction? ❑ Yes ❑ No

Do you have any concerns about your sexual function? For example, do you have trouble with maintaining an erection, ejaculation, achieving orgasm? ❑ Yes ❑ No

Do you have any concerns or questions about your sexual orientation, sexual identity, or sexual desires? ❑ Yes ❑ No

Sexuality, Gender Identity & Support

Do you feel you are getting enough support and acceptance of your sexuality and/or gender identity from friends and/or family? ❑ Yes ❑ No

Do you want to speak with anyone further (or join a support group) about any concerns you have about your sexuality and/or gender identity? ❑ Yes ❑ No

Patient Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____