Metro Nashville Health Department

SHC – Confidential Sexual Assessment Form

Instructions: Please complete the **confidential** sexual assessment questionnaire. If you have any questions or need further explanation, please ask a nurse during your appointment.

PATIENT LABEL

Medical History:

1. Please list any significant medical conditions (ie: diabetes, high blood pressure).

_____

2. Do you have any allergies?

□ No □ Not sure □ Yes

To what? _____

What happens?_____

3. Please list all current medications, including vitamins and supplements.

Medication Name	Dose	Number of times a day

Have you ever received a blood transfusion or organ transplant?

□ Yes □ No □ Not sure

Vaccinations:

Have you received the Human Papilloma Virus (HPV) Vaccine *(known as Gardasil)*?

□ Yes □ No □ Not sure

Have you received the Hepatitis B (HBV) Vaccine?

□ Yes □ No □ Not sure

Sexual History: What is your reason for visiting the clinic today?

□ STD/HIV testing (without symptoms)
□ Court ordered/Solicitation (without symptoms)
□ Experiencing symptoms
□ Referred by a partner
□ Referred by staff
□ Test Results
□ Treatment/Medication
□ Not sure
□ Other: _____

Were you informed by a sex partner that he/she has an STD? □ No □ Yes Which STD(s)?_____

Are you experiencing any of the following STD symptoms? :

GU: Discharge or bleeding? □ Yes □ No

Skin: Itching or irritation in the genital area? □ Yes □ No

Skin: Burning with urination? □ Yes □ No

GU: Rectal/anal bleeding or irritation? □ Yes □ No
Skin: Rashes, Sores or ulcers? □ Yes □ No
GI: Stomach and/or pelvic pain? □ Yes □ No
Skin: Rash on hands or feet? □ Yes □ No
Eyes: Any recent changes in vision? □ Yes □ No
Skin: Are you experiencing hair loss? □ Yes □ No
Ears: Any ringing in the ear? □ Yes □ No
Throat/Mouth: Sore throat? Sores in throat or mouth? □ Yes □ No

How many days have you had these symptoms? _____

Have you ever been tested for HIV/AIDS? □ Yes □ No
When was your last HIV test? (*mm/yy*) ___/___
What was your last HIV test result?
□ Negative □ Positive □ Indeterminate/Unknown

Have you ever been infected with:

Chlamydia □ Yes □ No
Gonorrhea □ Yes □ No
Genital Warts □ Yes □ No
Hepatitis B (HBV) □ Yes □ No
Hepatitis C (HCV) □ Yes □ No
Herpes □ Yes □ No
Syphilis □ Yes □ No
Trichomoniasis (Trich) □ Yes □ No

Sexual History (continued):

In the past 6 months, have you had sex with (check all that apply):

□ Men □ Women □ Both □ Neither

How often do you use condoms?

□ Always □ Sometimes □ Never

When was the last time you had vaginal, penile, oral or anal sex (given or received)? _____

What types of sexual acts have you engaged in within the past year:

Penis in vagina	□ Yes	□ No
Vagina to vagina	□ Yes	□ No
Anal sex (given)	□ Yes	□ No
Anal sex (received)	□ Yes	□ No
Oral sex (given)	□ Yes	□ No
Oral sex (received)	□ Yes	□ No

Is your current or recent sex partner having sex of any kind with someone else?

□ Yes □ No

In the past year have you had sex with a one-time sex partner and are unable to contact again (anonymous partner)?

□ Yes □ No

In the past year have you met any sex partners through the Internet or phone app?

□ Yes □ No

Hepatitis Screening:

There is currently an outbreak of Hepatitis A cases in Tennessee. Vaccination can protect you from contracting the disease. Have you ever had a Hepatitis A injection?

□ Yes □ No □ Unknown

If not, would you be interested in having one today?

□ Yes □ No

SHC Staff: I have reviewed the patient's medical, immunization, review of systems, sexual history and hepatitis screening information.

_____	_____	_____/____/_____
Provider Name	Provider Number	Date