Purchase College Student Health Services
Sexual Health Form

Name_____ **DOB**____/_____/____ **Age**_____ **Date**_____

Preferred Name _____ **Preferred Pronouns**_____

This form is ***PRIVATE*** and ***CONFIDENTIAL***

What is the reason for your visit today?

What is your anatomy?

☐ Vagina ☐ Penis ☐ Decline to answer

☐ It's complicated, please ask

What is your gender identity?

☐ Female ☐ Male ☐ Trans Female ☐ Trans Male

☐ Other/Non-binary _____

☐ Decline to answer

What is the total number of

Current partners? _____ ☐ Unsure

Past partners? _____ ☐ Unsure

☐ Decline to answer

What is your current/past partner(s) anatomy? (check all that apply)

☐ Vagina ☐ Penis ☐ Decline to answer

Have you had

Oral sex? ☐ Yes | ☐ No | ☐ N/A

Vaginal sex? ☐ Yes | ☐ No | ☐ N/A

Anal sex? ☐ Yes | ☐ No | ☐ N/A

Do you always use condoms with

Oral sex? ☐ Yes | ☐ No | ☐ N/A

Vaginal sex? ☐ Yes | ☐ No | ☐ N/A

Anal sex? ☐ Yes | ☐ No | ☐ N/A

When was the last time you had sex without a condom?

Do you have pain during or after sex? ☐ Yes | ☐ No

Do you have bleeding during or after sex? ☐ Yes | ☐ No

Do you use sex toys? ☐ Yes | ☐ No

Current Symptoms

Do you have any of the following symptoms?

☐ None ☐ Sores ☐ Bumps ☐ Warts ☐ Rash

☐ Itching ☐ Pain ☐ Blisters

☐ Discharge (describe): _____

☐ Swollen glands: if so, ☐ Painful ☐ Not painful

☐ Pain or burning with urination ☐ Blood in urine

☐ Frequent urination ☐ Pain on ejaculation

☐ Pain in rectum with bowel movement

☐ Pain in rectum during sex

☐ Other _____

Where are these symptoms located?

☐ N/A

☐ Vagina ☐ Penis/Testicles/Scrotum

☐ Rectum/Anus ☐ Throat/Mouth/Lips

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Name_____ **DOB**____/_____/____

STI History

Have you been tested for any STIs in the past?

☐ Yes ☐ No ☐ Unsure

If yes,

Date: _____ Results _____

Have you had

Chlamydia? ☐ Yes | ☐ No

Gonorrhea? ☐ Yes | ☐ No

Syphilis? ☐ Yes | ☐ No

Herpes? ☐ Yes | ☐ No

Genital warts? ☐ Yes | ☐ No

HIV? ☐ Yes | ☐ No

Other (please describe) _____

Were you treated for the described STI(s)?

☐ N/A ☐ Yes ☐ No

If yes, what was the medication _____

Was your partner(s) treated? ☐ Yes ☐ No ☐ Unsure

Does your current partner have symptoms or a diagnosis of an STI?

☐ Yes ☐ No ☐ Unsure

What is the diagnosis? _____ ☐ Unsure

Was your partner(s) treated? ☐ Yes ☐ No ☐ Unsure

Have you ever been tested for HIV?

☐ Yes Date of testing _____ ☐ No

What were the results?

☐ Positive ☐ Negative ☐ Unsure

Have you ever used a needle to inject drugs?

☐ Yes ☐ No ☐ Decline to answer

Have you had

Hepatitis A and B vaccinations? ☐ Yes | ☐ No | ☐ Unsure

Hepatitis A and B infection? ☐ Yes | ☐ No | ☐ Unsure

HPV (Gardasil) vaccination? ☐ Yes | ☐ No | ☐ Unsure

Meningitis vaccination? ☐ Yes | ☐ No | ☐ Unsure

Contraception

My current form of contraception is (check all that apply)

☐ N/A ☐ None ☐ Condoms ☐ Pull out method

☐ Birth control pills ☐ IUD ☐ Nexplanon

☐ Nuvaring ☐ Depo- Provera ☐ Hormonal Patch

☐ Emergency Contraception (Plan B)

☐ Other _____

Which contraceptive methods have you used in the past? When and why did you stop using this method?

Have you ever been pregnant?

Interpersonal Relationship History

Which forms of intimacy are important to you? (check all that apply)

☐ Talking ☐ Cuddling ☐ Kissing ☐ Sex

☐ Decline to answer ☐ Other

Do you feel you have equal decision-making power in your relationship(s)?

☐ Yes ☐ No ☐ Sometimes ☐ Decline to answer

Does your partner(s) treat you well? Do you feel safe around your partner(s)?

☐ Yes ☐ No ☐ Sometimes ☐ Decline to answer

Have you been a victim of interpersonal violence or sexual assault? This is CONFIDENTIAL. We want to ensure that you are safe at this time.

☐ Yes ☐ No ☐ Decline to answer

Please describe_____

Additional Information

Do you have any questions? Do you have anything else you'd like to tell us today?