Name: _____ DOB: _____

William Paterson University - Counseling, Health & Wellness Center

Annual Exam - Sexual Health History Form

Please circle and fill-in all that apply to you below

Your responses help us better understand how we may meet your medical needs

All information shared with our office is confidential and will not a part of your academic record.

Today's Date:_____ Age: _____ Contact #: _____ Ok to leave message? YES NO

Which sex were you assigned at birth?: Male Female No Sex

What is your gender identity?: _____

Reason for seeking services today: Annual Sexual Health Exam Having a problem Interested in Birth Control
STI/STD testing Other: _____

Have you ever had a genital exam?:	**NO**	**YES**	*most recent date?:* _____ *Normal Abnormal Not Sure*
Have you ever had a pap test?:	**NO**	**YES**	*most recent date?:* _____ *Normal Abnormal Not Sure*
Have you ever had test for a sexually transmitted infection (STI/STD)?:	**NO**	**YES**	*if yes, have you ever tested positive for a STI/STD?:* **NO YES** *if yes, which STI/STD & when?*_____
Have you ever had an HIV test?:	**NO**	**YES**	*most recent date?:*_____ *Result:* _____
Have you received the Gardasil/HPV vaccine?	**NO**	**YES**	*how many doses?* _____
Do you know how to perform a *BREAST* **or** *TESTICULAR* self-exam?	**NO**	**YES**	*if yes, do you perform the self-exams regularly?* **NO YES**

Have you ever had sex with anyone before? **YES** **NO*** *(if no, skip down to Medication History)*

Who have you had sex with?: Male Female Transgender Other: _____

How old were you when you first had sex? _____ When was the last time you had sex?: _____

How many partners have you had sex with in the last: 3 months? _____ 12 months? _____ Lifetime? _____

If yes to sexual activity, what type of sex have you had with another person?
Oral *(mouth on penis, vagina, or anus)*
Vaginal ((*penis in the vagina -or- vagina-to-vagina)*
Anal *(penis in the anus)*
If other, please clarify: _____

Do you use a barrier method (condoms/dental dams) for:
(Please answer all that apply to you)

Vaginal Sex?:	Always	Sometimes	Never	N/A
Oral Sex?:	Always	Sometimes	Never	N/A
Anal Sex?:	Always	Sometimes	Never	N/A

Did you agree with -and/or- give consent for all of your sexual experiences?	**NO**	**YES**
Has there ever been violence in your relationships?	**NO**	**YES**
Are you afraid of your partner?	**NO**	**YES**

MEDICATION HISTORY *(answer what applies to you)*

Are you now taking any medications/supplements?:	**NO**	**YES**	*List all:* _____
Have you ever taken/used birth control?	**NO**	**YES**	*Which one(s):*_____ *Dates used:* _____ *Reason you stopped using:* _____
Have you ever taken emergency contraception/Morning after pill?	**NO**	**YES**	*How many times?* _____ *Last used?* _____

Name: _____ DOB: _____

MENSTRUAL HISTORY:	Have you ever had a period? *Age of 1st period?* _____	**NOT APPLICABLE**	**NO**	**YES**

1st day of your most recent period: _____ How often do you typically get your period? *Every* _____ *days*

How many days does your period typically last? _____ On your heaviest day, how many pads/tampons do you use? _____

Do you currently use, or in the past used: deodorant tampons douche feminine hygiene sprays none

	NO	**YES**
Do you have any of the menstrual symptoms below *currently* or *recent* past? *(if yes, circle which ones):* Passing blood clots with period Missed/Irregular periods Bleeding between periods Painful cramps with period		
Do you experience any of the following symptoms *before* or *during* your periods? *(if yes, circle which ones):* weight gain bloating depression irritability headache breast tenderness fatigue increased appetite other: _____	**NO**	**YES**

PREGNANCY HISTORY:	Have you ever been pregnant?	**NOT APPLICABLE**	**NO**	**YES**

If yes, how many times?: _____ When did your most recent pregnancy end? _____

How many children born alive? _____ What type of deliveries? Vaginal birth _____ C-section _____

How many miscarriages? _____ How many abortions? _____ How many stillbirths? _____
Dates: _____ Dates: _____ Dates: _____

	NO	**YES**
Did you have any problems with your pregnancies?		

OTHER MEDICAL HISTORY: ***Mark X in the box to the right for your answer***	**NO**	**YES**	***Not Applicable***
Do you have repeated severe headaches/often on one side/ pulsating/nausea/worse with light/noise/movement?			
Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?			
Do you regularly take any pills for tuberculosis (TB), seizures (fits), or Ritonavir for ARV therapy?			
Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)?			
Have you Have you ever been told you have ever been told you have high blood pressure?			
Have you ever been told you have diabetes?			
Have you ever been told you have rheumatic disease such as lupus?			
Have you ever been told you have breast cancer?			
Have you ever been told you have prostate/testicular cancer?			
Do you have a history of frequent urinary tract infections?			
Have you ever had Prostatitis (inflammation of the prostate gland)?			
Have you ever had Testicular lumps/torsion/other?			

Please check any symptoms below that you are *currently* experiencing: No current symptoms ☐

O Fever/chills	O Bloody stools/bleeding with bowel movements
O Urinary symptoms *(increased frequency, pain, burning, blood)*	O Hemorrhoids and/or other Anal/Rectal skin problems
O Loss of urine/bed wetting	O Discharge from penis or blood in semen
O Vaginal discharge, irritation or itching	O Pain in testicles/scrotum and/or testicular lumps
O Vaginal dryness, decreased lubrication	O Difficulty achieving/maintaining an erection
O Skin rash, lumps or mumps on genital/rectal area	O Ejaculation problem
O Trauma/injury to genital/rectal areas	O Pain with intercourse
O Other:	

Do you smoke? **NO YES**	Do you drink alcohol? **NO YES**	Do you use any street/illicit drugs? **NO YES**

All of the information I provided on history form is true and accurate to the best of my knowledge,

_____ _____
Patient's Signature Date

Revised 6/9/16