Do you drink alcohol?  
- Yes  
- No  
If no, skip next section.

If yes, circle the answer that applies for the last 3 months:

- How often do you have a drink containing alcohol?  
  - Never  
  - Monthly or less  
  - 2-4 times a month  
  - 2-3 times a week  
  - 4 or more times a week
- How many drinks do you typically have when drinking?  
  - 1 or 2  
  - 3 or 4  
  - 5 or 6  
  - 7 to 9  
  - 10 or more
- How often do you have six or more drinks on one occasion?  
  - Never  
  - Less than monthly  
  - Monthly  
  - Weekly  
  - Daily or almost daily
- Has alcohol ever affected your sexual health?  
  - Yes  
  - No  
  - Have you ever experienced a blackout due to alcohol?  
  - Yes  
  - No

Do you use tobacco?  
- Yes  
- No  
If no, skip next section.

- Cigarettes - #/day  
- Chew - #/day  
- Vaping - #/day  
- Cigars - #/day
- # of years  
- Year quit  
- Have you quit more than once

Planning to quit:  
- now  
- considering quitting  
- no plan to quit

Please circle the recreational drug you currently use or have used in the past:
- Marijuana  
- Cocaine  
- Stimulants  
- Opiate Pain Medication (Percocet, Oxy)  
- Ecstasy  
- Heroin  
- Hallucinogens (LSD, Mushrooms, PCP)  
- Other

Any changes in home life?

Any new sexual partners since your last visit?

Any unprotected sex since your last visit?

What are you using for pregnancy prevention, if needed.

Do you want sexual transmitted infection (STI) testing today?

Do you feel safe with your partner?

Have you experience unwanted sexual activity in the last year?

When was your last pap smear?

Additional questions or concerns for your provider: