campus HEALTH

STI Screening Form

Visit Date:_____

PATIENT: COMPLETE PARTS 1-4 BELOW

Note: Some of these questions are personal and please discuss any you hesitate to answer with the Registered Nurse.

PART 1 – CHECK WHICH SYMPTOMS YOU HAVE

☐ No symptoms ☐ Discharge ☐ Pain ☐ Itching ☐ Urinary frequency/urgency/blood

Other symptoms:_____
Duration of symptoms?____

PART 2 – SEXUAL HISTORY

When was your last sexual encounter?_____
Do you partner with? ☐ Males ☐ Females ☐ Both
Last STI testing?_____ Which tests? _____ How many partners since last testing? ___
Have you experienced any recent unwanted sexual activity? ☐ No ☐ Yes
History of STI?_____

PART 3- SEXUAL PRACTICES

Oral Sex
Vaginal Sex
Anal Sex ☐Top (insertive) ☐ Bottom (receptive) ☐ Both

Part 4 – Prevention of STI's

How often do you use condoms/barriers? ☐ Always ☐ Most of the time ☐ Sometimes ☐ Never
Do you feel unsafe in your home, school or personal life? ☐ No ☐ Yes
Have you traveled outside the United States within the last 30 days? ☐ No ☐ Yes If Yes, where _____
Do you use? ☐ Alcohol ☐ Drugs ☐ History of IV drug use
Have you had 3 HPV vaccines?
Have you had 2 hepatitis A vaccines?
Have you have 3 hepatitis B vaccines?

PART 5

Are you allergic to any medications? ☐ No ☐ Yes If yes, specify_____

Current medications:_____

Method of contraception (if applicable):_____

First day of last menstrual (if applicable): _____

_____
Patient Signature

Student Wellness team has educators who can assist with further sexual health questions: 919-962-WELL (9455)