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)

UNC CHS 01/15, revised 2/15, 7/17, 10/17, 5/18, 1/21, 11/22