



## Sexual History Questionnaire

**\*\*Must be completed for all patients age 13 and above\*\***

Patient Name: \_\_\_\_\_ Patient Gender: M  F

Patient DOB: \_\_\_\_\_ LMP: \_\_\_\_\_ HcXUnd'8 UHY. \_\_\_\_\_

Have you had sex in the last 12 months (vaginal; oral; or, anal)? Yes  No

If YES:

with men only

with women only

with both men and women

If YES:

Was protection used? Yes  No

How often was protection used?

All of the time

Most of the time

90% of the time

80% of the time

70% of the time

60% of the time

Half of the time

Some of the time

20% of the time

10% of the time

None of the time



**Sexual History Questionnaire** continued  
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What prevention strategies would you like to discuss at your appointment?

Abstinence

Condoms

Other

Have you ever had an STD (Sexually Transmitted Disease)? Yes  No

If **YES**, please mark an **X** in the following boxes which apply:

Chlamydia

GC

Syphilis

Herpes

Other

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