UNIVERSITY OF ILLINOIS SPRINGFIELD

UIS Health Services • (217) 206-6676

SEXUAL HISTORY QUESTIONNAIRE

place label here
Name:
UIN:
Birth date:
Date:

Please take a few minutes to fill out these questions about your sexual health. Your information is **strictly confidential** – we will not share it with anyone unless you request us to do so. Your **honest** answers will help us provide the **BEST** possible care for you. If a question does not apply to you, please leave it blank. If you are unsure, please state this in the space provided.
***Sexual relationships** include any vaginal, anal, or oral sex that you have had with another person.

A. PERSONAL INFORMATION

Please choose one of the following that best applies to you:

- ❑ Male
- ❑ Female
- ❑ Transgendered – Male to Female
- ❑ Transgendered – Female to Male
- ❑ Intersexed
- ❑ Prefer not to answer

Do you/have you had a sexual relationship with: (check all that apply)

- ❑ Male
- ❑ Female
- ❑ Transgendered – Male to Female
- ❑ Transgendered – Female to Male
- ❑ Intersexed
- ❑ Not applicable (skip to Section D)

B. SEXUAL HISTORY

How old were you the first time you had sex? (oral, vaginal, anal) ______

Number of lifetime sexual partners: ______

Number of sexual partners in the last six months: ______

Number of new partners in the last three months: ______

Are you currently in a sexual relationship? ❑ Yes (please answer the next three questions) ❑ No

- Is this an exclusive/monogamous relationship? ❑ Yes ❑ No
  - If no, how many other sexual partners do you or your current partner have (if known)? ______
- How long have you been in this relationship? (months, years) ______

C. SEXUAL SAFETY

What type(s) of sexual intercourse have you had? (check all that apply)
❑ Oral (Given and/or Received) ❑ Vaginal ❑ Anal (Given and/or Received)

What method(s) do you and your partner(s) use to prevent pregnancy, if applicable? (check all that apply)
❑ Not applicable ❑ Nothing ❑ Male/female condoms
❑ Withdrawal ❑ Pills, shot, implant, patch ring, IUD
❑ Other (please specify): ______

How often do you use the above method(s)?
❑ Always ❑ Most of the time ❑ Sometimes ❑ Never

What method(s) do you and your partner(s) use to protect against sexually transmitted infections? (check all that apply)
❑ Condoms ❑ Oral barriers ❑ Long-term monogamy
❑ STD test for self ❑ STD test of contact/partner
❑ Other (please specify): ______

How often do you use the above method(s)?
❑ Always ❑ Most of the time ❑ Sometimes ❑ Never

When is the last time you tested for Sexually Transmitted Infections? ______ mth/yr ______ ❑ Never

Please check all that apply and list approximate date(s) of infection if possible:

- ❑ Chlamydia ______
- ❑ Gonorrhea ______
- ❑ Trichomonas ______
- ❑ Genital warts ______
- ❑ PID ______
- ❑ HIV ______
- ❑ Genital herpes ______
- ❑ Syphilis ______
- ❑ Other ______

Have you or a sexual partner ever...

	You:		Partner(s):		
• Had sex for money?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Unsure
• Paid for sex?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Unsure
• Had sex with a stranger?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Unsure
• Injected drugs?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Unsure
• Had sex while under the influence of alcohol or drugs?	❑ Yes	❑ No	❑ Yes	❑ No	❑ Unsure

D. MEDICAL HISTORY

Have you gotten the HPV vaccine series (Gardasil or Cervarix)?
❑ Yes, all 3 doses ❑ Yes, < 3 doses ❑ No ❑ I do not know

Have you ever had a painful or frightening sexual experience? ❑ Yes ❑ No

Do you feel safe in your current relationships? (family, friends, romantic) ❑ Yes ❑ No

Patient Signature: ______

Date: ______

Clinician Comments: ______

Clinician Signature: ______ Date: ______

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