

Columbus State University Student Health Services – Sexual History

Name: _____ Date: _____

909 _____ Age: _____ Race: _____ Ethnicity: _____

Do you have a history of physical or sexual abuse? Yes No

Have you ever been sexually active? Yes No

Your sex partners are: Men Women Both

Number of sex partners: **in the last month:** _____ **in the last 6 months:** _____

When was your last sexual encounter? _____

Last encounter was with: Male Female

What type of sex have you had? Vaginal Oral Anal

If Oral, do you: Give Receive Both

If Anal, do you: Give Receive Both

Do you use condoms or other protection when having sex? Never Sometimes Always

Have you ever had a Sexually Transmitted Infection? Yes No

Date(s) of infection: _____

Name(s) of the infection(s): _____

If you are you experiencing any symptoms now, what are they? _____

Have any of your **partners** ever had a Sexually Transmitted Infection? Yes No Unsure

If yes, name of the infection? _____

Have you been tested for HIV in the past 6 months? Yes No

Do you have a history of HIV? Yes No

Are you currently taking PrEP? Yes No

For Females:

What is the **1st Day** of your **last period**? _____

Have you ever been pregnant? Yes No

Have you taken Plan B? Yes No **If yes**, date that you took it: _____