Appendix D

Sample Sexual and Reproductive Health History Form
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Instructions
Fill in the following information as fully as possible. All of your answers are confidential. If you prefer, your provider will ask you the questions and mark the answers on the form for you.

Date: ____________________

Your name: ________________________________________________

Facility name: ______________________________________________

Facility number/code: ________________________________________

Date of birth: ____________________________       Age: ___________

Race/ethnicity: ____________________________________________

Preferred language: __________________________________________

Use of translator/relationship to client: __________________________

Allergies to medications: Yes _____  No _____

If so, identify the medication(s): ______________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

1. Why have you come to the health care facility today?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________
Family History (immediate family)

2. Do any members of your family have a history of:

- Cancer? Yes _____  No _____
  If so, identify the type(s) of cancer and the family member: ____________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- Congenital or genetic disorders? Yes _____  No _____
  If so, identify the disorder(s) and the family member: ________________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- Depression and/or other emotional illness? Yes _____  No _____
  If so, identify the illness(es) and the family member: ________________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- Diabetes? Yes _____  No _____
  If so, identify the family member: ________________________________________

- Heart disease? Yes _____  No _____
  If so, identify the family member: ________________________________________

- Heavy drinking, alcoholism, or other drug use? Yes _____  No _____
  If so, identify the type(s) of drug use and the family member: __________________
  ______________________________________________________________________
  ______________________________________________________________________
  ______________________________________________________________________

- High blood pressure? Yes _____  No _____
  If so, identify the family member: ________________________________________

- High cholesterol? Yes _____  No _____
  If so, identify the family member: ________________________________________
Family History (immediate family) *(continued)*

2. Do any members of your family have a history of: *(continued)*
   - Problems with impulse control (for example, anger, hitting, or violence)?
     Yes ______ No ______
     If so, identify the problem(s) and the family member: __________________________
     ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________
   - Do any members of your family currently have any other illnesses?  
     Yes ______ No ______
     If so, identify the illness(es) and the family member: __________________________
     ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________

Personal History

3. Do you have a history of:
   - Cancer?  
     Yes ______ No ______
     If so, identify the type(s) of cancer: ______________________________________
     ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________
   - Depression and/or other emotional illness?  
     Yes ______ No ______
     If so, identify the illness(es): __________________________________________
     ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________
   - Diabetes?  
     Yes ______ No ______
   - Heart disease?  
     Yes ______ No ______
   - Heavy drinking, alcoholism, or other drug use?  
     Yes ______ No ______
     If so, identify the type(s) of drug use: ________________________________
     ______________________________________________________________________
     ______________________________________________________________________
     ______________________________________________________________________
### Personal History (continued)

- High blood pressure? Yes ______ No ______
- High cholesterol? Yes ______ No ______
- Liver disease? Yes ______ No ______
- Lung disease? Yes ______ No ______
- Problems with impulse control (for example, anger, hitting, or violence)? Yes ______ No ______
  If so, identify the problem(s): ____________________________________________
  ____________________________________________
  ____________________________________________

- Smoking or other tobacco use? Yes ______ No ______
  If so, do you use tobacco occasionally (up to one pack per day, on average) or frequently (more than one pack per day, on average): ____________________________

4. Do you currently take any medications (including herbal remedies, over-the-counter medications, and vitamins)? Yes ______ No ______
   If so, identify the medication(s): ____________________________________________
   ____________________________________________
   ____________________________________________

5. Have you had any surgeries and/or been hospitalized? Yes ______ No ______
   If so, identify when and where: ____________________________________________
   ____________________________________________
   ____________________________________________

6. Have you been abused or been forced to have sex against your will? Yes ______ No ______
   If so, identify when: ____________________________________________
   ____________________________________________
   ____________________________________________
## STIs/HIV/AIDS Risk History

7. Are you protecting yourself from sexually transmitted infections (STIs), including HIV, the virus that causes AIDS?  
   Yes ______ No ______  
   If so, identify how: 
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

8. How many sexual partners have you had in the past 12 months?  ________________

9. Do you use condoms every time you have sex?  Yes ______ No ______

10. Have you used drugs that you injected using needles?  Yes ______ No ______

11. Do any of your partners use drugs that they inject using needles?  Yes ______ No ______

12. Have you had blood transfusions or blood products?  Yes ______ No ______  
   If so, identify when and where: 
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________

13. Do you have oral sex?  Yes ______ No ______  
   If so, do you give oral sex or do you receive oral sex:  ________________

14. Do you have anal sex?  Yes ______ No ______

15. Do you have sex with women, men, or both women and men?  Yes ______ No ______

16. Have you ever had an STI?  Yes ______ No ______ Don’t know ______  
   If so, identify the STI and when: 
   __________________________________________________________
   __________________________________________________________
   __________________________________________________________
STIs/HIV/AIDS Risk History (continued)

17. Do you know if you have had any of these infections:
   - Chlamydia? Yes ______ No ______
   - Chancroid? Yes ______ No ______
   - Donovanosis? Yes ______ No ______
   - Genital herpes? Yes ______ No ______
   - Genital warts or condyloma? Yes ______ No ______
   - Gonorrhea? Yes ______ No ______
   - Hepatitis or liver infection? Yes ______ No ______
   - HIV/AIDS? Yes ______ No ______
   - Nongonococcal urethritis (NGU)? Yes ______ No ______
   - Syphilis? Yes ______ No ______

18. Were you treated? Yes ______ No ______

19. Were your partners treated? Yes ______ No ______ Don’t know ______

20. Have you or your partners had:
   - Burning with urination? Yes ______ No ______ Don’t know ______
   - Difficulty urinating or dribbling? Yes ______ No ______ Don’t know ______
   - Penile discharge? Yes ______ No ______ Don’t know ______
   - Pain during defecation? Yes ______ No ______ Don’t know ______
   - Pain during ejaculation? Yes ______ No ______ Don’t know ______
   - Pain during sex? Yes ______ No ______ Don’t know ______
   - Pelvic infection? Yes ______ No ______ Don’t know ______
   - Rash on the body or the palms or soles of the feet? Yes ______ No ______ Don’t know ______
   - Sores on the penis? Yes ______ No ______ Don’t know ______
   - Sores on the vulva, labia, or vagina? Yes ______ No ______ Don’t know ______
   - Sore throat? Yes ______ No ______ Don’t know ______
   - Vaginal discharge? Yes ______ No ______ Don’t know ______

21. Do you practice genital self-examination? Yes ______ No ______
### STIs/HIV/AIDS Risk History (continued)

22. Is there anything else in your medical history that you would like to let me know?  
   Yes _____  No _____  
   If so, identify the condition:  
   _______________________________________________  
   _______________________________________________  
   _______________________________________________

### Other Health Issues

23. Do you know whether you have, or have had, any diseases, infections, injuries, or problems related to your:  

- **Bladder?**  
  Yes _____  No _____  
  If so, identify the condition:  
  _______________________________________________  
  _______________________________________________  
  _______________________________________________

- **Bones or muscles?**  
  Yes _____  No _____  
  If so, identify the condition:  
  _______________________________________________  
  _______________________________________________  
  _______________________________________________

- **Ears, nose, or throat?**  
  Yes _____  No _____  
  If so, identify the condition:  
  _______________________________________________  
  _______________________________________________  
  _______________________________________________

- **Eyes?**  
  Yes _____  No _____  
  If so, identify the condition:  
  _______________________________________________  
  _______________________________________________  
  _______________________________________________

- **Immune system?**  
  Yes _____  No _____  
  If so, identify the condition:  
  _______________________________________________  
  _______________________________________________  
  _______________________________________________
Other Health Issues (continued)

- Kidneys, penis, or testes? Yes _____ No _____
  If so, identify the condition:______________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

- Prostate gland? Yes _____ No _____
  If so, identify the condition:______________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

- Skin? Yes _____ No _____
  If so, identify the condition:______________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

- Gallbladder, intestines (bowel), pancreas, rectum, spleen, or stomach? Yes _____ No _____
  If so, identify the condition:______________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

- Thyroid, growth, or development? Yes _____ No _____
  If so, identify the condition:______________________________________________
  ________________________________________________________________
  ________________________________________________________________
  ________________________________________________________________

Reproductive and Contraceptive History

24. Have you had any children? Yes _____ No _____

25. Are you concerned about your fertility? Yes _____ No _____
Reproductive and Contraceptive History  
(continued)

26. If you are having a sexual relationship with a woman, which contraceptive method(s) are you and your partner using to prevent pregnancy?
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

Sexual History

27. Are you satisfied with your current level of sexual activity? Yes _____ No _____

28. Do you have any sexual concerns? Yes _____ No _____
    If so, identify the concern(s): ____________________________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________

29. Do you have concerns or questions about libido or sexual arousal? Yes _____ No _____
    If so, identify the concern(s) or question(s): _______________________________
______________________________________________________________________
______________________________________________________________________
______________________________________________________________________