Sexually Transmitted Disease Screening Questionnaire

Patient Name: __________________________ Visit Date: __/__/____

Date of Birth: _______ Gender: M / F

1. What race do you consider yourself? (Check at least one, and all that apply).
   ___White/Caucasian ___Black/African American ___Native American/Alaskan native
   ___Asian ___Hawaiian/Pacific Islander ___Other race

2. Do you consider yourself of Hispanic ethnicity? ____Yes ____No

3. (Women only) Date last menstrual period began: ____________

4. Have you ever been treated for an STD? ____Yes ____No Type: ______ When: ______

5. Are you allergic to any medications? If so, please list: _____________________________

6. Have you had any of these symptoms recently? (check all that apply):
   ___Abnormal discharge/drip from vagina or penis
   ___Burning or pain when you urinate (pee)
   ___(Women Only) Pelvic pain
   ___(Women Only) Abnormal vaginal bleeding
   ___No symptoms

7. In the past 60 days, how many people have you had sex with(vaginal/oral/anal)?____

8. In the past 60 days, did you start having sex with someone new? ____Yes ____No

9. Do you have someone steady, like a boyfriend/girlfriend/spouse that you have sex with?
   ____Yes ____No (if you checked No, SKIP to Question 10)
   9a. In the last 6 months how often did you use condoms with this person?
      ____Always
      ____Usually (more than half of the time)
      ____Sometimes (Less than half the time)
      ____Never
      ____I did not have sex with my steady partner in the last 6 months.

9b. Did you use a condom the last time you had sex with this person? ____Yes ____No

10. In the last 6 months have you had sex with anyone else (besides a steady partner)? ____
    (If “No”, skip the rest of the questions).
   10a. In the last 6 months how often did you use condoms with this person?
      ____Always
      ____Usually (more than half of the time)
      ____Sometimes (Less than half the time)
      ____Never
      ____I did not have sex with my steady partner in the last 6 months.

   10b. Did you use a condom the last time you had sex with them? ____Yes ____No

Clinician Signature_______________________ Date: ________________
College of the Canyons
Student Health & Wellness Center
GYNECOLOGIC HISTORY

Name: ___________________________ Date: __________________________
Age: _____ Date of Birth: _________ Country of Birth: ________________
Date of Last Menstrual Cycle: ____________________
Current Address: __________________________________________________

_____________________________________________________________

May we send test results to you at this address?  Yes / No

History

Reason for health center visit: _______________________________
Do you have PMS? (water retention, emotional changes, etc.)_________
Current birth control method: ________________________________
Menstruation began at age ____  Periods: regular / irregular every ___ days
Menstrual cramps?_____________ Bleeding between periods? _______
Did your mother take DES when pregnant with you? Yes / No/ Don’t know
Have you been taught breast self-exam?_____ Do you check yourself
    monthly?_____ How many pregnancies have you had? ____________
Please list any chronic illnesses you have: _________________________
Do you smoke? _______ How many/day? _____________________________
Do you live with a smoker?_______________________________________
Use alcohol?____ How many drinks/day or week?_____________________
Do you use recreational drugs?____________________________________
Do you use herbal remedies/vitamins/other non-prescription
    meds?_____________________________________________________
Do you have a family history of:  Breast Cancer____ Diabetes________
    High Blood Pressure____ Thyroid disease____ Heart attack or
    stroke ________ Asthma/allergies________ Other_________________
When was your last mammogram?______ Pap test?_______ Screening test
    for sexually transmitted infection_______ Any abnormal tests? _______
Have you ever been abused, in your current or a past relationship? _______
When was your last dental exam? ______ Do you use a seatbelt? _______
Do you use sunscreen?____ Do you have any skin problems?___________
When was your last Tetanus shot?_______ Measles vaccine? _______
Did you have chickenpox as a child?_____ Are you on a diet?___________
What do you do for exercise?______________________________________
College of the Canyons  
Student Health & Wellness Center  
MALE GENITO-URINARY HISTORY

Name:__________________________________ Date:_________________
Age:_____ Date of Birth:_________ Country of Birth:_______________
Date of Last Menstrual Cycle:______________
Current Address:_____________________

May we send test results to you at this address?  Yes   /   No

History

Reason for health center visit:____________________________
Current birth control method:___ condoms___ withdrawal ___ depend on partner’s
birth control method_____ other
Have you ever had unprotected sex?  Yes  / No  
My sexual partners have been:  male / female / both
Have you had, or do you currently have: ___abnormal penile discharge or drip
___ burning pain when you urinate ___bumps or rash on penis or groin 
Did your mother take DES when pregnant with you?  Yes / No/ Don’t know
Have you been taught testicular self-exam?____ Do you check yourself
regularly?____
Please list any chronic illnesses you have:___________________________
Do you use tobacco in any form? ______
Do you live with a smoker?______________________________________
How many times in the past year have you had 5 or more alcoholic drinks in a
day?____________________
Do you use recreational drugs (marijuana/ecstasy/speed, etc)?___________
Do you use herbal remedies/vitamins/or non-prescription meds?__________
Do you have a family history of:  Breast Cancer_____ Diabetes__________
High Blood Pressure_____ Thyroid disease_____ Heart attack or
stroke______ Asthma/allergies__________ Other______________
My last screening test for sexually transmitted infection was ______. Any
abnormal results?____
Have you ever been abused, in your current or a past relationship?_______
When was your last dental exam?_____ Do you use a seatbelt?__________
Do you use sunscreen?____Do you have any skin problems?_____________
When was your last Tetanus shot?_____ Measles vaccine?__________
Did you have chickenpox as a child?_____ Are you on a diet?____________
What do you do for exercise?____________________________________