

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? _____