SNHD Southern Nevada Health District
CLINICAL SERVICES

Sexual Health Clinic
Client Health History

Label

Please complete this form as much as possible. All information is confidential

Todays' Reason for Visit	
☐ No symptoms or problems, I just want testing ☐ Call from Health Dept. ☐ I have an appointment ☐ Partner/Doctor told me to come ☐ Other (please explain):	☐ I have symptoms **(check all that apply)** ☐ Abnormal discharge ☐Odor ☐Itching ☐Rash ☐ Burning when I pee ☐ Abdominal Pain ☐ Sores/bumps in genital area ☐ Swelling/pain in testicle(s) ☐ Other (please explain):

PATIENT MEDICAL HISTORY Have you ever been told by a doctor, nurse, or other health professional that you have:		**FAMILY HISTORY** (parents, sibling)?	**If yes, list person**
Diabetes? Check all that apply ☐ Gestational Diabetes ☐ Prediabetes ☐ Borderline Diabetes	☐ Yes ☐ No	☐ Yes ☐ No	
Heart attack, angina coronary health disease or stroke?	☐ Yes ☐ No	☐ Yes ☐ No	
High blood pressure/or high cholesterol?	☐ Yes ☐ No	☐ Yes ☐ No	
Cancer?	☐ Yes ☐ No	☐ Yes ☐ No	
Mental Illness?	☐ Yes ☐ No	☐ Yes ☐ No	
Kidney Disease or Urinary Tract Infections?	☐ Yes ☐ No	☐ Yes ☐ No	
Seizures?	☐ Yes ☐ No	☐ Yes ☐ No	
Asthma, TB or Lung Problems?	☐ Yes ☐ No	☐ Yes ☐ No	
Hepatitis/Liver problems?	☐ Yes ☐ No	☐ Yes ☐ No	

Other Chronic Health Problems:

Hospitalizations:

Prior sexually transmitted diseases (check all that apply): ☐ Chlamydia ☐ Gonorrhea ☐ Syphilis ☐ Trichomoniasis ☐ Herpes ☐ Genital Warts ☐ Hepatitis ☐ Pelvic inflammatory disease

Diagnosed with HIV? ☐ Yes ☐ No IF yes, the date diagnosed: _____

Diagnosed with AIDS? ☐ Yes ☐ No IF yes, the date diagnosed: _____

Do you see a doctor/provider? ☐ Never ☐ Within past 6 months ☐ More than year

Date last seen by provider: _____ Where: _____ Reason: _____

_____

Did you receive a flu vaccine this year: ☐ Yes ☐ No Other vaccines?

Allergies (drugs/ others)? ☐ Yes ☐ No If yes, list:

List all HIV medications ever taken:

List all other medications taken **in the past 2 weeks:**

FEMALES ONLY: Date of last period: _____ Date of last Pap smear: _____ Pregnant? ☐Yes ☐No ☐Unsure

Do you use birth control? ☐ Yes ☐ No If yes, list:

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SOCIAL HISTORY

Do you use tobacco products such as: (check box)
☐Cigarettes ☐ Smokeless tobacco ☐ Electronic vapor product ☐Hookah ☐ Pipe ☐ Chew

Do you: (check box) ☐ Drink alcohol ☐Take street drugs ☐Inject drugs ☐ Share needles/equipment

Are you experiencing domestic violence, sexual violence or human trafficking?
☐ Yes ☐ No If **yes**, would you like information or help today? ☐ Yes ☐ No

SEXUAL HISTORY

Have you traveled outside of the United States in the past 60 days? ☐ Yes ☐ No **If yes, where?**

# of sexual partners in the last 90 days _____	# of sexual partners in the last 12 months _____	# of sexual partners in your lifetime _____	When was the last time you had sex? _____

In the last 12 months I have had sex with:(check all that apply)

☐Women ☐ Men ☐ Transgender Date of last sexual activity:_____
☐ **Steady partners** *(people you regularly have sex with)* # of **different** *steady* partners last 3 mons.____
☐ **Casual partners** *(people that you don't have sex with very often)* # of **different** *casual* partners last 12 mons. ____

In the last 12 months my sexual activities include:

Oral sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐
Anal sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐
Vaginal sex	☐ Give	☐ Receive	☐ None	If **within last 3 months** check here ☐

I use condoms for... **vaginal sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A
I use condoms for... **anal (rectal) sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A
I use condoms for... **oral sex**	☐ Always	☐ Sometimes	☐ Never	☐ N/A

Exchanging sex for drugs, money or place to live?	☐ Yes	☐ No	
Having sex while intoxicated or high on drugs?	☐ Yes	☐ No	
Did any of your partners have an STD (including HIV)?	☐ Yes	☐ No	☐ Unsure

Was any of your partners that you had sex with: (check all that apply)
☐HIV positive ☐ IV Drug User ☐ Exchanging sex for drugs/money

***FEMALES ONLY*:**
I have had vaginal or anal (rectal) sex with a man who has sex with men ☐ Yes ☐ No ☐ Unsure

SIGNATURE

I have answered all the questions correctly to the best of my knowledge.

_____ _____ _____
Print Name of Client **Signature** **Date**