Comprehensive Sexual History Template

# Purpose

This comprehensive sexual history template was created for use by clinicians to assess potential health risks associated with an individual’s sexual history and behavior. This template includes questions that are recommended at the initial patient visit for baseline, and some that should be asked at the initial visit as well as at follow-up visits for routine screening and testing of bacterial sexually transmitted infections (STIs). Users are free to modify the template for their own settings.

# Contributing Authors

* Christine Brennan, PhD, APN, Louisiana State University Health Science Center, New Orleans, LA
* Andrew Chandranesan, MD, Louisiana State University Health Science Center, Shreveport, LA
* Kathleen Cullinen, PhD, RD, Rutgers School of Nursing
* Shanna Dell, MPH, RN, HRSA HIV/AIDS Bureau, Rockville, MD
* Terry Estes, Southwest Louisiana AIDS Council, Lake Charles, LA
* Beth Gadkowski, MD, University of Florida, Gainesville
* Ana Gomez, Andromeda Transcultural Health, Washington, D.C.
* Macsu Hill, PhD, MPH, Rutgers School of Nursing, Newark, NJ
* Mary Jo Hoyt, MSN, Rutgers School of Nursing, Newark, NJ
* Jennifer Janelle, MD, University of Florida, Gainesville
* Veronica Jones, MPH, Rutgers School of Nursing, Newark, NJ
* Gay Koehler-Sides, RN, Alachua County Health Department, Gainesville, Florida
* Austin Matthews, MSW, LCSW, CareSouth, Baton Rouge, LA
* Puja H. Nambiar, MD, Louisiana State University Health Science Center, Shreveport, LA
* John A. Nelson, PhD, APN, Rutgers School of Nursing, Newark, NJ
* Andrea Norberg, DNP, MSN, Rutgers School of Nursing, Newark, NJ
* Peter Oates, MSN, APN, Rutgers School of Nursing
* Michael Serlin, MD, Family and Medical Counseling Service, Washington, D.C.
* John Vanchiere, MD, Louisiana State University Health Science Center, Shreveport, LA
* Fredericka Vertinord, Orange County Health Department, Orlando, FL
* Rick Vitale, Bay County Health Department, Panama City, FL
* Ron Wilcox, MD, Howard University, Washington, D.C.
* Barbara Wilgus, MSN, APN, Johns Hopkins University, Baltimore, MD

# References

* U.S. Centers for Disease Control and Prevention. [A Guide to Taking a Sexual History](https://www.cdc.gov/std/products/provider-pocket-guides.htm). Accessed October 8, 2019.
* National LGBT Health Education Center and National Association of Community Health Centers. (2015). [Taking Routine Histories of Sexual Health: A System-Wide Approach for Health Centers](https://www.lgbthealtheducation.org/publication/taking-routine-histories-of-sexual-health-a-system-wide-approach-for-health-centers/).

This resource is supported by the Health Resources and Services Administration (HRSA) and the U.S. Department of Health and Human Services (HHS) under grant number U90HA32147 (Improving Sexually Transmitted Infection Screening and Treatment among People with or at Risk for HIV). The contents are those of the author(s) and do not necessarily represent the official views of, nor an endorsement, by HRSA, HHS or the U.S. Government.

1. What is your current gender identity?

* Male
* Female
* Transgender Male/Transgender Man/ Female-to-Male (FTM)
* Transgender Female/Transgender Woman/ Male-to-Female (MTF)
* Gender Non-Binary, Genderqueer
* Additional Gender Category  
  Specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Choose not to disclose

1. What sex was assigned to you at birth (on your original birth certificate)?

* Male
* Female
* Choose not to disclose

1. Do you think of yourself as:

* Straight or heterosexual
* Lesbian or gay or same-gender loving
* Bisexual or pansexual
* Something else
* Don’t know
* Choose not to disclose

1. How old were you the first time you had sex (oral, vaginal, or rectal), if ever: \_\_\_\_\_\_\_\_\_\_\_
2. Have you ever had sex (oral, vaginal, or rectal) with a man (or person with a penis)?

* No
* Yes

*If yes, how many* *(in your lifetime, over the past year, over the past 30 days):* \_\_\_\_\_\_

1. Have you ever had sex (oral, vaginal, or rectal) with a woman (or person with a vagina)?

* No
* Yes

*If yes, how many (in your lifetime, over the past year, over the past 30 days):* **\_\_\_\_\_\_\_\_\_\_\_**

1. Have you ever had oral sex?

* No
* Yes

*If yes, which types:*

* partner’s mouth to your genitals
* partner’s mouth to your anus
* your mouth to partner’s genitals
* your mouth to partner’s anus

1. Have you ever had anal sex?

* No
* Yes

*If yes, which types:*

* anal insertive (your penis in your partner’s rectum)
* anal receptive (your partner’s penis in your rectum)

1. Have you ever had vaginal sex?

* No
* Yes

1. Have you ever used inanimate object(s), such as dildos, sex toys, vibrators, for stimulation during sex?

* No
* Yes

*If yes, have you shared the object(s) with a sexual partner at the time of use?*

* No
* Yes

1. Have you ever received or given money or housing or food for sex?

* No
* Yes

*If yes, with how many different sexual partners (in your lifetime, over the past year, over the past 30 days):* \_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever used recreational drugs (for example, marijuana, meth, or cocaine) before or during sex?

* No
* Yes

*If yes, which drug(s), and how often (in your lifetime, over the past year, over the past 30 days):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Have you ever been drunk when having sex?

* No
* Yes

*If yes, how often (in your lifetime, over the past year, over the past 30 days):* \_\_\_\_\_

1. Have you ever been forced to have sex or been sexually abused/mistreated?

* No
* Yes

*If yes, how many times (once, twice, many times, on a regular basis):* \_\_\_\_\_\_\_

1. Which of the following venues have you ever met sexual partner(s) – check all that apply:

* Internet (or apps)
* Bath house
* Cruising area
* Bar/Club

1. Have you ever had (been diagnosed with) any of the following:

| Condition | Last treatment | No | Unsure | Yes | Number of times |
| --- | --- | --- | --- | --- | --- |
| Gonorrhea |  |  |  |  |  |
| Chlamydia |  |  |  |  |  |
| Syphilis |  |  |  |  |  |
| Hepatitis C Virus (HCV) |  |  |  |  |  |
| Non-gonococcal urethritis (NGU) or  non-specific urethritis (NSU) |  |  |  |  |  |
| Trichomonas vaginitis |  |  |  |  |  |
| Pelvic inflammatory disease (PID) |  |  |  |  |  |
| Herpes or Herpes Simplex Virus (HSV) |  |  |  |  |  |
| Genital warts or human papillomavirus (HPV) |  |  |  |  |  |
| Crabs or scabies |  |  |  |  |  |
| Molluscum contagiosum |  |  |  |  |  |
| Chancroid |  |  |  |  |  |
| Lymphogranuloma venereum (LGV) |  |  |  |  |  |
| Methicillin-resistant Staphylococcus aureus (MRSA) |  |  |  |  |  |
| Other |  |  |  |  |  |

1. Have your current or any past sexual partner(s) been diagnosed or treated for a STI?

* No
* Yes
* Unsure

*If yes, what was the infection and/or treatment?*  
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Do you know the HIV status of your partner(s)?

* No
* Yes
* Some yes, some no

*If yes, when were they your sexual partner and what was their status(es):* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. If you have only one sexual partner, does this partner or do you think this partner recently has had sex with other people in addition to you?

* No
* Yes
* Unsure

1. Which methods do you use for HIV and STI transmission prevention (check all that apply):

* External “male” condom. If yes, for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Sometimes | Most times | Always |
| oral sex |  |  |  |  |
| vaginal sex |  |  |  |  |
| rectal sex |  |  |  |  |

* Internal “female” condom. If yes, for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Sometimes | Most times | Always |
| oral sex |  |  |  |  |
| vaginal sex |  |  |  |  |
| rectal sex |  |  |  |  |

* Dental dam. If yes, for:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Never | Sometimes | Most times | Always |
| oral sex |  |  |  |  |
| vaginal sex |  |  |  |  |
| rectal sex |  |  |  |  |

* Pre-Exposure Prophylaxis (PrEP)
* Undetectable HIV viral load with antiretroviral therapy (ART)
* Post-Exposure Prophylaxis (PEP)

1. Which methods do you or your partner(s) currently use for contraception (check all that apply):

* Abstinence
* Diaphragm/Cervical Cap
* Female Condom
* Female Sterilization (tubes tied)
* Fertility Awareness
* Hormonal Implant
* Hormonal Injection  
   – 1 Month
* Hormonal Injection (Depo) - 3 Month
* Hormonal Patch
* Intrauterine Device (IUD)
* Male Condom
* Oral Contraceptive   
  (birth control pills)
* Spermicide
* Vaginal Ring
* Vasectomy
* Other Method
* No Method

1. Are you (or your partner) trying to get pregnant or have a child?

* No
* Yes
* Unsure

1. Do you (or your partner) want to get pregnant or have a child within the next year?

* No
* Yes
* Unsure