**Comprehensive Sexual History Template**

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**Purpose:**

This comprehensive sexual history template was created for use by healthcare clinicians across the United States and its territories (U.S.) for assessing potential health risks associated with an individual’s sexual health. 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).

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**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/Other, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Choose not to disclose

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

Male

Female

Choose not to disclose

**3. 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

**4. How old were you the first time you had sex (oral, vaginal, or rectal), if ever:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. 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): \_\_\_\_\_\_

**6. 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): \_\_\_\_\_\_

**7. 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

**8. Have you ever had vaginal sex?**

* No
* Yes

**9. 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)

**10. 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

**11. Have you ever received/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): \_\_\_\_\_\_\_\_\_\_\_\_\_

**12. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. 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): \_\_\_\_\_

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

* No
* Yes

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

**15. 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

**16. Have you ever had:**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | NO | UNSURE | YES | How many times? | Last Treatment |
| Gonorrhea |  |  |  |  |  |
| Chlamydia |  |  |  |  |  |
| Syphilis |  |  |  |  |  |
| HCV |  |  |  |  |  |
| Non-gonococcal urethritis (NGU) or non-specific urethritis (NSU) |  |  |  |  |  |
| Trichomonas vaginitis |  |  |  |  |  |
| Pelvic inflammatory disease (PID) |  |  |  |  |  |
| Herpes or HSV |  |  |  |  |  |
| Genital Warts or HPV |  |  |  |  |  |
| Crabs or scabies |  |  |  |  |  |
| Molluscum contagiosum |  |  |  |  |  |
| Chancroid |  |  |  |  |  |
| LGV |  |  |  |  |  |
| MRSA |  |  |  |  |  |
| Other |  |  |  |  |  |

**17. 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? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**18. 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19.** **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

**20. 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-genital sex |  |  |  |  |
| oral-anal sex |  |  |  |  |

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

**21. 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

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

* No
* Yes
* Unsure

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

* No
* Yes
* Unsure