

IUPUI Health Services  
STI Questionnaire

Name \_\_\_\_\_ Birthdate \_\_\_\_\_ Today's date \_\_\_\_\_

Please answer the following questions regarding your sexual history and any current symptoms. Your answers will help determine your treatment. Thank you.

Please list any medications you take on a regular basis: \_\_\_\_\_  
\_\_\_\_\_

Please list any medication allergies: \_\_\_\_\_

Why do you want STI testing? \_\_\_\_\_  
\_\_\_\_\_

<b>Sexual history:</b>		
Age at first sexual encounter _____		
Number of sexual partners in last 3 months _____ In last 6 months _____		
Number of times a condom was used in your last 5 sexual encounters _____		
Have you had oral sex?	Y	N
Have you had vaginal sex?	Y	N
Have you had rectal sex?	Y	N
When was the last time you had sex of any type with a partner? _____		
Have you had a sexually transmitted infection?	Y	N
If yes, please list the year and type of infection _____		

<b>Symptoms</b>		
Are you having an abnormal discharge?	Y	N
If yes, does it itch?	Y	N
Does it burn, itch or tingle when you urinate?	Y	N
Are you urinating more frequently than usual?	Y	N
Have you noticed a different odor of urine or discharge?	Y	N
Do you or have you had any sores in your mouth or genital area?	Y	N
Are you having any rectal symptoms?	Y	N
Have you noticed a rash?	Y	N
<b>Men only:</b> Do you have any testicular pain?	Y	N
<b>Females only:</b>		
Is sex painful?	Y	N
Do you have spotting after sex?	Y	N
Are you having abdominal or pelvic pain?	Y	N
Date of first day of last period ____/____/____		
Number of pregnancies _____ Number of deliveries _____		
<b>Both sexes</b>		
Have you had any of your current symptoms in the past?	Y	N
If yes, what was the cause? _____		

Refer to progress notes for objective info, assessment and plan

Reviewed by: \_\_\_\_\_ Date \_\_\_\_\_