Portland State University
Student Health Service
Sexual Health History Form

Name ____________________________________  Today’s Date ____________________

ID # __________________________  Birth Date __________________________  Age ____________

Phone number we have your permission to call ________________________________

If we are unable to reach you, a message and call back number will be left from “PSU Student Services”

Purpose of today’s visit? ________________________________________________________________

Date of last STI (Sexually Transmitted Infection) screening __________________________

Have you ever, or since your last STI screening:

Yes No
☐ ☐ Been advised to seek medical attention for a possible exposure?
☐ ☐ Been diagnosed or treated for an STI or hepatitis?
☐ ☐ Had unprotected sex with someone that you think may be infected with an STI?
☐ ☐ Had unprotected vaginal, oral, or anal intercourse with more than one sex partner?
☐ ☐ Had anonymous sex partners?
☐ ☐ Shared sex toys with more than one sex partner?
☐ ☐ Been sexually involved with a known IV drug user?
☐ ☐ Exchanged sex for drugs or money?
☐ ☐ Had sex with someone who exchanged sex for drugs or money?
☐ ☐ Used substances that may have led to unsafe sex practices or behaviors?
☐ ☐ Gotten a tattoo or body piercing?
☐ ☐ Been forced to have sex with anyone?

Number of sexual partners in the last 6 months _________  Lifetime __________

Are your partners ☐ male  ☐ female  ☐ transgender

Do you have a steady sexual partner? ________  Duration with this partner __________

Do you or your partner have other sex partners? __________

If needed, what birth control method do you and your partner(s) use? __________________________

Do you use condoms? ________  What % of the time with your current partner(s)? ________

Have you been physically or emotionally harmed by your partner or someone close to you? ______

Have you had Hepatitis B immunizations? __________  If no, would you like information?

Have you had Gardasil (HPV) immunizations? __________  If no, would you like information?

Check any symptoms you are experiencing now:

Men
☐ Burning with urination  ☐ Bumps or sores in the rectal/genital area
☐ Discharge from penis  ☐ Lumps or pain in groin area
☐ Rash  ☐ Other symptom __________________________

Women
☐ Unusual vaginal discharge  ☐ Bumps or sores in vaginal/rectal area
☐ Unusual vaginal bleeding  ☐ Lumps or pain in groin area
☐ Unusual cramping/abdominal pain  ☐ Rash
☐ Unusual pain during intercourse  ☐ Other symptom __________________________

First day of your last menstrual period ________  Was it typical? ________

Are you pregnant now or planning a pregnancy? __________

Date of last Annual/PAP ________  Any abnormal PAP results? __________________________