Plymouth State University

HEALTH SERVICES

STD Questionnaire

Name:_____Phone:_____

Date:_____Date of Birth:_____

All information is private and remains confidential

1. At what age did you become sexually active?_____

2. How many partners have you had? Lifetime partners_____

Partners this year_____

3. Have you had unprotected vaginal/anal/oral sex (sex without using a condom)? □Yes □ No

4. Have you had any experience with intravenous drug use? □Yes □No

5. Have you had problems with unusual infections, unexplained fatigue, night sweats, chronic diarrhea or unexplained weight loss? □Yes □No

6. For females only: Have you had any abnormal vaginal discharge, pain during intercourse or bleeding between menstrual periods? □Yes □No

7. For males only: Have you had a discharge from the penis, a burning sensation when urinating or burning or itching around the opening of the penis? □Yes □No

8. Have there been any unusual blisters, bumps, or sores in your genital area? □Yes □No

9. Have you or a partner had a positive STD test in the past? □Yes □No

10. For females only: Have you had the HPV vaccine? □Yes □No

To protect yourself, remember these ABC's
A=Abstinence
B=Be faithful
C=Condoms

Nursing Check List Plan

□ Patient STD questionnaire reviewed by nurse

□ Lab tests ordered for patient

□ Lab tests refused by patient

Signature:_____Date:_____