The Faythe Medical Centre

178 The Faythe, Wexford. Tel.: 053-9142355, Fax: 053-9141160, www.tfmc.ie

SEXUAL HEALTH QUESTIONNAIRE

Name:

Addresss:

D.o.B.:

Telephone number:

History of Presenting Complaint:

Discharge ☐ Bleeding ☐ Skin ☐ Pain ☐ Other ☐

Sexual Health Screen (No symptoms) ☐

History of Sexual Intercourse:

Last sexual contact: ___________ days/weeks/months ago. Protected ☐ Unprotected ☐

Partners in the last six months: ______________

Contraception: Yes ☐ No ☐ Type: ____

Same Sex Contacts in Past: Yes ☐ No ☐

Last Passed Urine: ____________________ hours ago (men must hold urine for 2 hours for accurate test)

Previous History of STI's: Yes ☐ No ☐ Details: ____

Sexual Contact Abroad Recently: Yes ☐ No ☐ Location & Dates: ________________________

Obs/Gynae History:

Pregnancies: ______________________ Last period: ______________________

Last cervical smear: ____

Smoker: Yes ☐ No ☐ Quantity: _______________________________

Tattoos: Yes ☐ No ☐ If yes, in what country: _____________________________

IV Drug Use: Yes ☐ No ☐ Details: _______________________________

Past Medical History:

Allergies: