

Patient ID Number

Patient D.O.B.



Date:

## SEXUAL HEALTH CHECK UP FORM

The following questions are designed to help us decide which member of staff will be able to meet your needs best and in the quickest time. In some circumstances the support worker will be able to help you without the need to see anyone else. However we need to find out if you have any symptoms or if you are at increased risk of certain infections, in which case you will need to see a trained nurse or health adviser and/or a doctor.

**We ask the following questions of everyone, so please do not be offended.**

	Yes	No
Are you under 16?	<input type="checkbox"/>	<input type="checkbox"/>

Please can you tick the box or boxes below which indicate your reason(s) for attending?

- Pregnancy test
- Condoms
- Chlamydia and Gonorrhoea tests only
- Full sexual health check-up – Chlamydia, Gonorrhoea, HIV and Syphilis

	Yes	No
Have you had any antibiotics in the last 2 weeks?	<input type="checkbox"/>	<input type="checkbox"/>

(If yes, we will still offer you baseline tests today and advise you to return in 2-3 weeks.)

**If any of the following questions result in “yes” – you may be referred to a nurse or doctor for a further discussion and/or tests.**

### Women Only

- Unusual vaginal discharge
- Genital rashes, spots, sores, blisters, lumps/swellings, itching
- Lower abdominal pain
- Pain during sex
- Pain/burning when passing urine (peeing)
- Period problems
- Bleeding in between your periods or after sex
- Sexual contact with a female

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input checked="" type="checkbox"/>	<input type="checkbox"/>

### Men Only

- Discharge from penis
- Pain/burning on passing urine (peeing)
- Genital rashes, spots, sores, blisters, lumps/swellings or itching
- Pain or swelling in testicles
- Sexual contact with a male

Yes	No
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/>	<input type="checkbox"/>

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**All clients**

- |   | <b>Yes</b>               | <b>No</b>                |
|---|--------------------------|--------------------------|
| • Have you had more than 3 sexual partners in the last 6 months?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever had sex with anyone who was born or who has lived in a country outside of the UK? | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever paid or been paid for sex?  | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever had sex with a person who has injected or snorted drugs?                          | <input type="checkbox"/> | <input type="checkbox"/> |
| • Have you ever injected or snorted drugs yourself?   | <input type="checkbox"/> | <input type="checkbox"/> |

	<b>Yes</b>	<b>No</b>
Have you <u>ever</u> had a sexually transmitted infection?	<input type="checkbox"/>	<input type="checkbox"/>
If yes, what was the infection? .....		
If yes, when was it treated? .....		

**If all of the above questions result in “no”, you will be offered the following:**

- **Male patients** – urine tests for Chlamydia and Gonorrhoea and a test for HIV and Syphilis.
- **Female patients** – self-taken swab from vulva/vagina for Chlamydia and Gonorrhoea and a test for HIV and Syphilis.

<b>How would you describe your sexuality?</b>	
Please tick appropriate box	
1. Heterosexual/straight	<input type="checkbox"/>
2. Homosexual – lesbian woman / gay man	<input type="checkbox"/>
3. Bisexual	<input type="checkbox"/>
4. Not known / not stated	<input type="checkbox"/>

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**FOR STAFF ONLY TO COMPLETE**

Questions resulting in a "yes" - client must be referred to a clinician

Questions resulting in a "yes" – need only be discussed with a clinician

<b>ACTION</b>		<b>COMMENTS</b>
Patient under 16	Yes/No	Under 16 form to be completed
Pregnancy test	Yes/No	Perform according to protocol
Issue condoms	Yes/No	Perform according to protocol
Wants Chlamydia & Gonorrhoea tests - please state if done on urine sample or swab		Perform according to protocol
Wants HIV & Syphilis tests – please state if done on blood test or mouth swab		Perform according to protocol
Refer nurse/doctor/health adviser	Yes/No	

Contact details checked i.e. address/telephone number(s)? Yes/No

Client advice sheet given? Yes/No

Chlamydia & gonorrhoea information sheet given? Yes/No

Need to discuss patient with senior nurse/doctor?	Yes/No
Patient needs to be seen by senior nurse/doctor?	Yes/No

Record of discussion with senior nurse/doctor or any other relevant information:
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Name of HCW/Nurse seeing patient \_\_\_\_\_

Signature of HCW/Nurse seeing patient \_\_\_\_\_

Date \_\_\_\_\_