

Sarah Lawrence College Health Services
SEXUALLY TRANSMITTED DISEASE ASSESSMENT

PLEASE PRINT AND COMPLETE THE FOLLOWING FORM AND BRING IT TO YOUR APPOINTMENT

INSTRUCTIONS PRIOR TO APPOINTMENT:

FEMALES:

- DO NOT USE DOUCHES OR VAGINAL PRODUCTS FOR 48 HOURS PRIOR TO APPOINTMENT
- SCREENS ARE MORE ACCURATE IF NOT DONE DURING MENSES- PLEASE SCHEDULE APPROPRIATELY OR RESCHEDULE IF NEEDED.

MALES:

- DO NOT URINATE FOR 2-3 HOURS BEFORE EXAM

Name: _____ DOB: _____ Date: _____

Please check the reason(s) for your visit today:

No symptoms, want STI screen _____ Possible symptoms of an STI _____ Known Exposure to an STI _____

Current medications/Birth Control _____

Allergies _____ **Smoker:** no ___ yes ___ # cig per day _____

Alcohol: _____ drinks per week **Recreational drugs:** _____

We define sexual activity as any intimate physical contact between partners that involves some form of genital / anal/oral/ stimulation or arousal that may involve exposure to blood, semen, saliva, or vaginal secretions.

I became sexually active for the first time at age _____ I use safe sex (condom, dental dam): _____ always
 In my lifetime, I have had _____ partners. _____ never
 I have had _____ partners in the past year. _____ sometimes

My partners have been ___ male ___ female ___ both

My sexual history includes:

Oral sex _____ Intercourse _____ anal sex _____ Use of sex toys _____ Manual stimulation _____ Sexual assault or violence _____

FOR WOMEN:

Check if you have any of the following:

- _____ unusual vaginal/ rectal discharge /odor
- _____ vaginal/vulval itching, burning, or pain
- _____ sore/bump/ swelling
- _____ pain with or frequent urination
- _____ abdominal /pelvic pain
- _____ joint pain
- _____ rash
- _____ swollen glands
- _____ weight loss / fatigue
- _____ abnormal vaginal bleeding

Last menstrual period started _____

Check if you have a personal history of:

- _____ yeast infections _____ Trich
- _____ bacterial vaginosis _____ Syphilis
- _____ gonorrhea _____ Chlamydia
- _____ genital / anal warts _____ genital herpes
- _____ recurring urinary infection
- _____ abnormal PAP; when _____

FOR MEN:

Check if you have any of the following:

- _____ discharge from penis/rectum
- _____ itching, burning or pain in penis/ testicle/rectum
- _____ visible sore /bump/swelling
- _____ pain with urination or ejaculation
- _____ Abdominal /pelvic pain
- _____ joint pain
- _____ rash
- _____ swollen glands
- _____ weight loss/ fatigue

Check if you have a personal history of:

- _____ hernia _____ Trich
- _____ Gonorrhea _____ Chlamydia
- _____ genital / anal warts _____ genital herpes
- _____ Syphilis
- _____ testicular/scrotal injury or surgery
- _____ rectal pain /fissure/ discharge/ bleeding