

Medical History Form: Sex Work

All information is voluntary and subject to confidentiality.

General

Reason for today's consultation: _____

Current complaints: _____

Contact requiring clarification, _____ weeks ago

Relationship model: No committed relationship Monogamous relationship Open relationship

Last menstruation _____ weeks ago Last cancer screening (month, year) _____

Have you ever been pregnant? Yes No If yes, how many _____ Number of births/ abortions? _____

Known surgeries or illnesses: _____

Do you take any medication? If yes, which ones? _____

Examinations

Have you already been tested for the following diseases?

Hepatitis A Yes No If yes, when was the last time? _____

Hepatitis B Yes No If yes, when was the last time? _____

Hepatitis C Yes No If yes, when was the last time? _____

HIV Yes No If yes, when was the last time? _____

Syphilis (Lues) Yes No If yes, when was the last time? _____

Gonorrhea Yes No If yes, when was the last time? _____

Chlamydia Yes No If yes, when was the last time? _____

Previous Illnesses

Have you or have you had any of the following diseases?

Hepatitis A Yes No Syphilis (Lues) Yes No

Hepatitis B Yes No Gonorrhea Yes No

Hepatitis C Yes No Chlamydia Yes No

HIV Yes No Other sexually transmitted diseases: _____

Sexual Orientation / Contacts

Sexual orientation: heterosexual homosexual bisexual other

Number of sexual partners over the past 12 months _____

Who have you had sexual contact with? Men Women Non-binary

At least one of my previous sexual partners... is homosexual is a bisexual man
 is HIV-positive has a sexually transmitted disease
 has injected drugs is engaged in sex work

How long have you been engaged in sex work? (Month, year) _____

What is included in your workplaces? Brothel Club Escort Apartment
 Appointment Apartment Massage salon Street work
 Other

Prevention

What are you vaccinated against? Hepatitis A Hepatitis B HPV

How often do you practice safer sex? Always Frequently Occasionally Never

What do you use to protect against sexually transmitted diseases? Condom Dental dam Gloves
 PrEP (Pre-exposure prophylaxis) Protection through therapy
 Other

Would you like information about PrEP (Pre-exposure prophylaxis)? Yes No

Risk information

Unprotected vaginal intercourse Yes No If yes, when was the last time? _____

Unprotected anal intercourse Yes No If yes, when was the last time? _____

Unprotected oral intercourse Yes No If yes, when was the last time? _____

Other risky situations Yes No If yes, specify _____

No known risky situations

Comments

Do you have any questions or additional comments? _____
