

Medical History Form: HIV-STI-Consultation

All information is voluntary and subject to confidentiality.

General

Reason for today's consultation: _____

Current complaints: _____

Contact requiring clarification, _____ weeks

Relationship model: ☐ No committed relationship ☐ Monogamous relationship ☐ Open relationship

Examinations

Have you already been tested for the following diseases?

Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
Syphilis (Lues)	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____
Chlamydia	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, when was the last time?	_____

Previous Illnesses

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

Hepatitis A	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Syphilis (Lues)	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis B	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Gonorrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hepatitis C	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Chlamydia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
HIV	<input type="checkbox"/> Yes	<input type="checkbox"/> 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

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? _____
