Dr. Sean Nixon
Dr. Peter Harrington
Dr. Tom Breslin
Dr. Nalini Ambiavagar

Dr. Joe Gallagher
Dr Csaba Abel
Dr Declan Breslin
Dr Andrée Rochfort

The Palms GP Surgery

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SEXUAL HEALTH QUESTIONNAIRE

Name:_____ Address:_____

Date of Birth:_____ Age:_____ _____

Tel:_____ _____

History of Presenting Complaint:

Discharge ☐ Bleeding ☐ Skin ☐ Pain ☐ Other ☐ Sexual Health Screen (No symptoms) ☐

If yes to any of above, please advise our specialist nurse at the appointment.

History of Sexual Intercourse:

Last sexual contact:_____ days/weeks/months ago. Protected ☐ Unprotected ☐ Partners in the last six months:_____

Contraception: Yes ☐ No ☐ Type:_____

Sexual Orientation/same sex contacts in the past: Yes ☐ No ☐

Last past Urine: _____ hours ago (men must hold urine for 2 hours for accurate test).

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

_____

Nationality of partner(s): Yes ☐ No ☐ Location & Dates:_____

Obs/Gynae History:

Pregnancies:_____ Last Period:_____ Last Cervical Smear:_____

Smoker: Yes ☐ No ☐ Quantity (per day):_____

Tattoos/Body piercings: Yes ☐ No ☐ if yes, in what country:_____

IV Drug Use/ Hx of snorting drugs: Yes ☐ No ☐ Details:_____

_____

Previous blood transfusion/Ever donate blood/Previous HIV test:_____

_____

Medical hx/allergies:_____

Type of Sexual Contact. Please tick appropriate box:

H/S Male: Vaginal ☐ Anal/I ☐ O/I ☐

MSM: O/R/I ☐ Anal R/I ☐ Receptive ORO-Anal

Female: O/R ☐ V/R ☐ A/R