Sexually Transmitted Infection (STI) Questionnaire

Instructions: Please complete this form and bring it your appointment.

Please note: This form contains no identification and will <u>not</u> be part of your medical record. If you have questions about this form, please discuss them with your clinician.

Date of Last STI Screening: __/__/____

Please answer the following questions as best as you can:

Have you…	YES	NO	DON'T KNOW
Received the Hepatitis B Vaccine (3 shots)?			
Received the HPV Vaccine (Gardasil or Cervarix, 2 shots)?			
Received the Hepatitis A Vaccine (2 shots)?			
Had intercourse with men?			
Had intercourse with women?			
Had intercourse with a sex worker?			
Had > 5 lifetime sexual partners?			
Received a blood transfusion?			
Accidentally been exposed to a needle or blood?			
Shared needles?			
Used condoms on a regular basis?			
Have you ever been diagnosed with an STI (including HPV, genital warts or herpes/cold sores)? If yes, please indicate which one(s) below:			
STIs:			