Date:

Name:

DOB: Label

Please answer all the questions on both sides. Thanks.
The doctor/nurse will ask you to clarify where necessary.

1 What can we do for you today?

I have a booked appointment. ☐

Other ☐
Please provide as much information as possible so that you are seen by the right person.

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2 Alcohol can sometimes contribute to sexual health problems. So please answer the following questions and add up your score. Thanks.
Note: 1 unit* = ½ pint of mid strength beer or = 1 small (125ml) glass of wine or = single spirit.

1 How often do you have **SIX** or more units* on one occasion?
Never ☐ **0** Less than monthly ☐ **1** Monthly ☐ **2** Weekly ☐ **3** Daily or almost daily ☐ **4**

2 How often, during the last year, have you been unable to remember what happened the night before because you had been drinking?
Never ☐ **0** Less than monthly ☐ **1** Monthly ☐ **2** Weekly ☐ **3** Daily or almost daily ☐ **4**

3 How often, during the last year, have you failed to do what was normally expected of you because of drink?
Never ☐ **0** Less than monthly ☐ **1** Monthly ☐ **2** Weekly ☐ **3** Daily or almost daily ☐ **4**

4 In the last year has a relative or friend, or a doctor or health-worker been concerned about your drinking or suggested you cut down?
No ☐ **0** Yes, on one occasion ☐ **2** Yes, on more than one occasion ☐ **4**

Your score= ☐ 0-2? Well done! You seem to be drinking within recommended limits.

Please Turn Over

3 Please answer questions as fully as you can. If you are unsure or have problems answering, the doctor or nurse will go over it with you.

Question	Answer
Have you ever had any of the following?	DVT (clot in leg/lung) □, Sexually Transmitted Infection □ Migraine □, heart disease □, stroke □, cancer □, NONE □
Has your mother/father/brother/sister had any of the following?	Heart disease □, stroke □, breast cancer □, DVT (clot in leg/lung) □, NONE □
Do you smoke?	No:□ Yes: □
Do you use a method of contraception?	Not applicable:□ No:□ Yes:□ which? →
Have you had sex without contraception, (eg the pill or condoms) since your last period?	Not applicable:□ No:□ Yes:□
Are you taking any medicines?	No:□ Yes: what? →
Are you allergic to any medicines?	No:□ Yes: what? →
Have you ever been pregnant?	Not applicable:□ No:□ Yes: □
When did you last have a cervical 'smear'? →	Not applicable:□
What date did your last period begin? →	Not applicable:□
Have you ever had an HIV test?	No: □ Yes: when most recently? →
Have you ever donated blood?	No: □ Yes: when most recently? →
Have you ever knowingly had sexual contact with someone who has HIV or viral hepatitis?	No: □ Yes: □
Who have you ever had sexual contact with?	Men: □ Women: □ Men & Women: □
Have you ever had sexual contact with someone who is from outside the UK?	No: □ Yes: □ which country?→
Have you ever injected drugs, including steroids?	No: □ Yes: □
Have you ever had sexual contact with someone who has injected drugs?	No: □ Yes: □
Have you ever been sexually assaulted or abused?	No: □ Yes: □
Have you ever experienced physical or emotional abuse by a partner, or genital cutting or mutilation?	No: □ Yes: □
Have you ever had contact with the sex industry?	No: □ Yes: □
Have you had sexual contact with anyone new in the last 3 months?	No: □ Yes: □
If not, have you had sexual contact with anyone new in the last 12 months?	No: □ Yes: □ Not applicable:□
With those new contacts, how often did you use a condom?	I always used one: □ I sometimes/never used one: □

**** Thank You ****