Personal Data Sheet

Name _____ **Date of Birth** _____

Reason for Visit Today _____

Please answer the following:

			Sexual History		
Do you have vaginal intercourse?	**Y**	**N**	Total number of partners (Lifetime)?		
Do you have oral sex?	**Y**	**N**	Number of partners last 6 months?		
Do you have anal sex?	**Y**	**N**	Intercourse with someone in another state?	**Y**	**N**
Do you have sex with males?	**Y**	**N**	Name of State?		
Do you have sex with females?	**Y**	**N**	Is your current partner with you today?	**Y**	**N**
Have you had an STD	**Y**	**N**	Has your partner been treated for an STD	**Y**	**N**
Name of STD _____			Name of STD partner treated for?		
Were you treated?	**Y**	**N**	Partners name:		
Do you have sex for money?	**Y**	**N**			
Do you have sex with prostitutes?	**Y**	**N**	**Contraceptive History**		
Do you use IV drugs?	**Y**	**N**	Do you use birth control?	**Y**	**N**
Do you use illegal drugs?	**Y**	**N**	Name of birth control		
Do you use alcohol?	**Y**	**N**	Do you use condoms?	**Y**	**N**
			Do you use condoms every time?	**Y**	**N**
Medication and Allergies			Are you interested in birth control?	**Y**	**N**
Do you have medication allergies?	**Y**	**N**			
What are you allergic to?			**Pregnancy History (Female Clients Only)**		
Current Medications (List)			Are you currently pregnant?	**Y**	**N**
			Date of last menstrual period		

Nurse Notes

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_____ _____ _____

Client Signature **Date** **Nurse Signature**

ALL MEDICAL SERVICES ARE PROVIDED ON A CONFIDENTIAL AND NON-DISCRIMINATORY BASIS.