women's center for health

CONFIDENTIAL STD DATA

please PRINT all information clearly

Patient's Name _____ Physician _____

It is recommended by the Center for Disease Control and The American College of Obstetrics and Gynecology that all patients who are at high risk for sexually transmitted diseases be screened for those diseases as well as for HIV (AIDS Virus). Please help us help you by answering the following questions to the best of your ability.

	YES	NO
1. Have you received blood or blood products between 1978 and 1985.	☐	☐
2. Have you ever used intravenous drugs?	☐	☐

3. How many sexual partners have you had?

☐ One ☐ Less than 5 ☐ 5 – 10 ☐ More than 10

4. Have you ever been involved in prostitution?	☐	☐
5. Have you ever been sexually exposed to someone with AIDS or to someone with a heightened risk of being infected with HIV (homosexual, bi-sexual, substance abuser, hemophiliac, or someone who has received multiple blood transfusions)?	☐	☐
6. Do you have or have you ever had a sexually transmitted disease?	☐	☐

If YES, what type? _____

Thank you for your honesty.

Patient's Signature _____ Date _____