Do you drink alcohol?
☐ Yes
☐ No
If no, skip next section

Any medication changes?

Do you need a medication refill today?

Any new allergies?

Any change in your medical history?

New surgeries/hospitalizations?

Do you drink alcohol?

☐ Yes
☐ No
If no, skip next section

If yes, circle the answer that applies for the last 3 months.

How often do you have a drink containing alcohol?

Never
Monthly or less
2-4 times a month
2-3 times a week
4 or more times a week

How many drinks do you typically have when drinking?

1 or 2
3 or 4
5 or 6
7 to 9
10 or more

How often do you have six or more drinks on one occasion?

Never
Less than monthly
Monthly
Weekly
Daily or almost daily

Has alcohol ever affected your sexual health?

☐ Yes
☐ No

Have you ever experienced a blackout due to alcohol?

☐ Yes
☐ No

If yes, circle the recreational drug you currently use or have used in the past:

Marijuana  Cocaine  Stimulants  Opiate Pain Medication (Percocet, Oxy)  Ecstasy  Heroin  Hallucinogens (LSD, Mushrooms, PCP)  Other

Any changes in home life?

Any new sexual partners since your last visit?

Any unprotected sex since your last visit?

What are you using for pregnancy prevention, if needed?

Do you want sexual transmitted infection (STI) testing today?

Do you feel safe with your partner?

Have you experience unwanted sexual activity in the last year?

When was your last pap smear?

Additional questions or concerns for your provider: