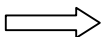
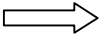
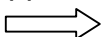
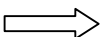


HIGHLAND SEXUAL HEALTH: HEALTH QUESTIONNAIRE

Are you taking any medication, including any bought by yourself?	<input type="checkbox"/> No <input type="checkbox"/> Yes – please provide details								
Do you have any allergies?	<input type="checkbox"/> No <input type="checkbox"/> Yes – please provide details								
Have you ever had any major health problems including operations?	<input type="checkbox"/> No <input type="checkbox"/> Yes – please provide details								
Has your mother/father/brother/sister had any of the following?	<input type="checkbox"/> VTE – blood clot in leg or lungs <input type="checkbox"/> Breast cancer								
Are your sexual partners	<input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Both								
When was the last time you had sex									
Have you had sexual contact with anyone new in the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes  How many?								
Have you ever suffered physical, sexual or emotional abuse by a partner?	<input type="checkbox"/> No <input type="checkbox"/> Yes								
Do you smoke	<input type="checkbox"/> No never <input type="checkbox"/> No stopped  How long ago? <input type="checkbox"/> Yes  How many?								
Have you or one of your sexual partner's ever injected drugs?	<input type="checkbox"/> No <input type="checkbox"/> Yes I have <input type="checkbox"/> Yes a partner has								
FOR FEMALE PATIENTS ONLY									
Do you use a method of contraception?	<input type="checkbox"/> No <input type="checkbox"/> Yes  Which one?								
Do you think you are at risk of being pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes								
What date did your last period start									
When did you last have a cervical 'smear' test?									
Have you ever been pregnant?	<input type="checkbox"/> No <input type="checkbox"/> Yes - please provide numbers of <table border="1" data-bbox="679 1921 1366 2114"> <tr> <td>Live births</td> <td></td> </tr> <tr> <td>Miscarriages</td> <td></td> </tr> <tr> <td>Ectopic</td> <td></td> </tr> <tr> <td>Termination of pregnancy</td> <td></td> </tr> </table>	Live births		Miscarriages		Ectopic		Termination of pregnancy	
Live births									
Miscarriages									
Ectopic									
Termination of pregnancy									

RECOGNISING HARMFUL DRINKING

Alcohol can sometimes contribute to sexual health problems. Please answer the following questions and add up your score.

1 Unit = ½ Pint Beer 1 Small Glass of Wine (125mls) 1 Single Spirit Measure

	0	1	2	3	4
How often do you have 6 units of more on any single occasion?	Never	Less than monthly	monthly	weekly	Daily or almost daily
How often during the last year, have you been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	monthly	weekly	Daily or almost daily
How often during the last year, have you failed to do what was expected of you because of drink?	Never	Less than monthly	monthly	weekly	Daily or almost daily
In the last year has a relative, friend or doctor or healthcare professional been concerned about your drinking and suggested you cut down?		Yes on one occasion			Yes on more than one occasion

Your Score

Scored 2 or less? Well done you seem to be drinking within normal limits