NHS
Maidstone and Tunbridge Wells NHS Trust

The Rubin Clinic - Integrated Sexual Health

Please answer all questions, print clearly and tick appropriate boxes. Information provided is confidential.

TITLE: …. **FIRST NAME:** …….. **SURNAME:**…….…… **AGE:**…… **DATE OF BIRTH:**…….

GENDER: Male ☐ Female ☐ Trans F ☐ Trans M ☐ **OCCUPATION:**……

ADDRESS:……

…… **POSTCODE**……

CONTACT NUMBER:……

How would you like us to contact you? **Phone** Yes/No **Text** Yes/No **Can we leave a voicemail?** Yes/No

NATIONALITY:…… **COUNTRY OF BIRTH:**……

MARITAL STATUS: Single ☐ Married ☐ Civil Partnership ☐ Separated ☐ Divorced ☐ Cohabiting ☐

ETHNICITY (please tick box):

A White British		B White Irish		C Any other White		D White and Black Caribbean	
E Mixed White and Black		F Mixed White and Asian		G Other Mixed		H Indian	
I Pakistani		K Bangladeshi		L Any other Asian Background		M Black Caribbean	
N Black African		O Other Black Background		R Chinese		S Any other Ethnic Category	
Z Not given							

Do you need any Communication Support? Yes/No If yes, what support do you need?.....

Do you need written information in another format? Yes/No If yes what format do you need?……

GP NAME:…… **SURGERY ADDRESS:** ……

If necessary may we contact your GP? Yes ☐ No ☐
(We would only contact your GP with your permission or in an emergency)

REASON FOR ATTENDING THE CLINIC: Own Accord ☐ GP's Advice ☐ Partner's Request ☐

Do you have a long term disability? Yes ☐ No ☐

If yes, please state what disability you have? ……

Was this your preferred clinic? Yes ☐ No ☐

When did you first try to access our service with this problem?
☐ Up to 2 working days
☐ Over 2 working days but less than a week
☐ Over a week but less than 2 weeks
☐ Over 2 weeks
☐ Not Known

Do you have a current problem or symptom? Yes ☐ No ☐
Have you contacted your GP about your problem? Yes ☐ No ☐

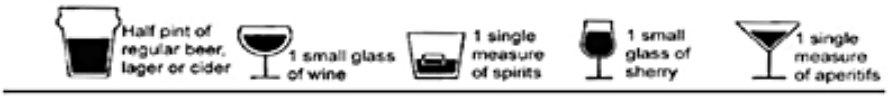
It is the policy of this department to write to your GP if you have been referred here by letter or if you request us to do so. You are entitled to receive copies of all correspondence with your GP or other hospital departments. Please indicate if you wish to receive copies of correspondence by signing the declaration below

Do you wish to receive copies of correspondence with your GP? Yes ☐ No ☐

Signed…… Date……

Please take this form to reception once completed.

This is one unit of alcohol...



...and each of these is more than one unit

Questions	Scoring system					Your score
	0	1	2	3	4	
How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times per month	2 - 3 times per week	4+ times per week	
How many units of alcohol do you drink on a typical day when you are drinking?	1 -2	3 - 4	5 - 6	7 - 9	10+	
How often have you had 6 or more units if female, or 8 or more if male, on a single occasion in the last year?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you failed to do what was normally expected from you because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you needed an alcoholic drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
How often during the last year have you had a feeling of guilt or remorse after drinking?	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	
Have you or somebody else been injured as a result of your drinking?	No		Yes, but not in the last year		Yes, during the last year	
Has a relative or friend, doctor or other health worker been concerned about your drinking or suggested that you cut down?	No		Yes, but not in the last year		Yes, during the last year	

Scoring: 0 – 7 Lower risk, 8 – 15 Increasing risk,
16 – 19 Higher risk, 20+ Possible dependence

TOTAL

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MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Clinic no: ……

Date: ……

Tell us why are you here today?

MALES AND FEMALES:	**FEMALES:** I have symptoms:
☐ **I have nothing wrong with me** and want a full sexual health check	☐ Unusual discharge/itching ☐ Unusual bleeding between period or after sex ☐ Pain in lower tummy ☐ Sores or broken skin ☐ Lumps on your skin ☐ I am pregnant ☐ Other (please specify) …… ……
☐ **I have symptoms** and want a full sexual health check (please fill in second column) →	
☐ **I am here for contraception** ☐ I need **emergency** contraception ☐ I would like to talk to someone about an unplanned **pregnancy** ☐ I have been in **contact with an infection** ☐ I have come back for **treatment/vaccination** ☐ I need **PEP** or **PEP** follow up ☐ I need **PREP** or **PREP** follow up ☐ I have been **sexually** assaulted recently (within the last 4 weeks)	**MALES:** I have symptoms: ☐ Discharge ☐ Discomfort/pain when passing urine ☐ Rectal symptoms (please specify) …… …… ☐ Sores or broken skin ☐ Lumps on your skin ☐ Other (please specify) …… ……
☐ I have been given a referral letter to show you today	

Your Gender: **Male** ☐ **Female** ☐ **Transgender** ☐ **Other** ☐

Date of birth …… **Age** ……..

Some questions about you – please write N/A if not applicable to you

Who do you have sex with?	Men	Women	Men and Women
When was the last time you had vaginal/anal sex without a condom?	……		
What form of contraception are you using (if any)?	……		
When was your last period?	……		
Have you passed urine in the last hour?	Yes	No	
Have you ever been treated for Syphilis?	Yes	No	
Have you ever been tested for HIV?	Yes	No	
If yes, when was your last HIV test?	……		
Are you allergic to any medication?	Yes	No	
If yes, which?	……		

Do any of the following apply to you?

I am HIV positive	Yes	No	Don't know
I had sex with an HIV+ person	Yes	No	Don't know
I have injected drugs	Yes	No	
I had sex with someone who injected drugs	Yes	No	Don't know
I had sex with a bisexual/gay man	Yes	No	Don't know
I had sex with a person from an area where HIV Is more common (eg Africa, South East Asia)	Yes	No	
Have you been vaccinated against Hepatitis B?	Yes	No	Don't know

If yes, please give details ……

MTW Sexual Health
exceptional people, outstanding care