

MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST

Clinic no:

Date:

Tell us why are you here today?

<p>MALES AND FEMALES:</p> <p><input type="checkbox"/> I have nothing wrong with me and just want an STI check -up</p> <p><input type="checkbox"/> Have you passed urine in the last hour? Yes / No</p>	<p>FEMALES ONLY: I have symptoms:</p> <p><input type="checkbox"/> Unusual discharge/itching</p> <p><input type="checkbox"/> Unusual bleeding between period or after sex</p> <p><input type="checkbox"/> Pain in your lower tummy</p> <p><input type="checkbox"/> Sores or broken skin</p> <p><input type="checkbox"/> Lumps on your skin</p> <p><input type="checkbox"/> I am pregnant or I think I am pregnant</p> <p><input type="checkbox"/> Other (please specify)</p> <p>.....</p> <p>OR</p> <p>MALES ONLY: I have symptoms:</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Discomfort/pain when passing urine</p> <p><input type="checkbox"/> Rectal symptoms (bleeding/pain/discharge in/around the bottom)</p> <p><input type="checkbox"/> Sores or broken skin</p> <p><input type="checkbox"/> Lumps on your skin</p> <p><input type="checkbox"/> Other (please specify)</p> <p>.....</p>
<p><input type="checkbox"/> I have symptoms and want a full sexual health check (please fill in second column) </p>	
<p><input type="checkbox"/> I am here for contraception</p> <p><input type="checkbox"/> I need emergency contraception</p> <p><input type="checkbox"/> I would like to talk to someone about an unplanned pregnancy</p>	
<p><input type="checkbox"/> I need HIV PEP/PEPSE following a risk in the last 72 hrs</p> <p><input type="checkbox"/> I need follow up/advice and am taking HIV PEP/PEPSE</p> <p><input type="checkbox"/> I want to discuss HIV PREP</p> <p><input type="checkbox"/> I need HIV PREP follow up bloods/ medication</p>	
<p><input type="checkbox"/> I have been sexually assaulted - please circle how long ago this occurred Less than 4 wks / More than 4 wks ago</p> <p><input type="checkbox"/> I have been in contact with an infection</p> <p><input type="checkbox"/> I have come back for treatment/vaccination</p> <p><input type="checkbox"/> I have been given a referral letter to show you today</p>	

Your Gender: Male Female Transgender Other

Date of birth Age

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

Would you describe yourself as ...? Gay Straight Bisexual Prefer not to say

When was the last time you had unprotected sex? (eg days/ weeks/months ago)

What form of contraception are you using (if any)? (write NONE if not using anything)

When was your last period?

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?(eg weeks/months/ years ago)

Are you allergic to any medication? Yes No

If yes, please write which medication (s) if known

Do any of the following apply to you?

I am HIV positive	Yes	No	Don't know
I have had unprotected sex with an HIV+ person	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	
If yes, please give details			
I have injected drugs	Yes	No	
I had sex with someone who injected drugs	Yes	No	Don't know
Have you been vaccinated against Hepatitis B?	Yes	No	Don't know

Clinic Use ONLY Triage Outcome	<input type="checkbox"/> Attend WI today	<input type="checkbox"/> Book appointment within 48 hours	<input type="checkbox"/> Smart kit issued	<input type="checkbox"/> Other outcome(state)
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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

