

What to Do Before Your Wellness and Sexual Health Visit

- Review and complete the enclosed personal history form (Pre-Visit Survey). This will allow us to focus the visit on relevant evaluation and education. Remember to bring the form with you when you come for your visit.
- Don't Urinate.** It is not possible to accurately test for Gonorrhea and Chlamydia within two hours of the urethra's being flushed with urine.
- Review the document *About the Wellness and Sexual Health Visit*. Spend some time thinking about what testing you feel you need.

The fees for tests will be charged to your student account as "miscellaneous lab fees". If you prefer to pay by an alternate method (cash or check at the time of the appointment), please notify the provider during your visit.

Your appointment is scheduled for _____

at _____.

Sexual Health Services at Davison Health Center

The Davison Health Center at Wesleyan University offers undergraduate and graduate students the full range of STI education, counseling and testing services, including HIV testing. The services are offered to students without regard to their sexual identity or partner gender, except insofar as the risks engendered by particular sexual practices indicate testing for specific infections.

All Health Center clinicians are qualified to offer all such services. Because many students seem to feel more comfortable with a provider of a particular gender, we make every effort to accommodate their preference. In urgent or emergent situations, we have less flexibility.

As a college health center, we have a special interest in education, and the bulk of our sexual health visits consist of providing information and answering questions. We all very much enjoy the opportunity to help students achieve emotionally and physically fulfilling sex lives, though we do not, of course, discriminate against students who are not sexually active.

The typical sexual health exam begins with risk-assessment. This is accomplished by asking explicit questions about current and past sexual practices. Based on this review, the clinician and patient will agree on what testing to do.

STI	Test(s)
HPV	History and physical exam (no charge). Pap smear if indicated (\$35, an additional \$45 applies for HPV typing if abnormalities are detected).
Herpes (genital)	History and physical exam (no charge). Swab test of skin outbreak (\$20, an additional \$18 applies for Herpes typing if Herpes is detected). Blood test for those with outbreak more than 4 months ago (about \$150).
Chlamydia	Swab or urine specimen depending on exam/anatomy (\$25.00).
Gonorrhea	Swab or urine specimen depending on exam/anatomy (\$25.00).
HIV	Rapid test (20-40 minute turn-around) (\$30) Blood test with 10-day turn-around (\$27). Blood test with 3-day turn-around (\$45).
Syphilis	Blood test (\$13).
Other	Several other vaginal disorders can be tested-for by examination of collected specimens.

In addition, annual exams/Pap smears and contraceptive counseling and services are provided. The Health Center dispenses birth control pills (limited brands), NuvaRings, and diaphragms at reasonable costs. We prescribe and deliver (but do not stock) DepoProvera injections. Condoms are provided free.

Tests are billed to the student account as a Miscellaneous Lab Fee. Some students pay at the time of testing. Test results are discussed in a follow-up visit except when rapid HIV testing is used (it is widely held ethical standard that HIV test results in particular be conveyed only in person). Positive results of non-HIV tests will be promptly communicated.

Any part of the testing may be declined. Some patients opt simply for counseling and education. Although we advise testing, it is the right and responsibility of the individual to direct the details of their visit.

All visits are conducted in the strictest confidence. All testing is confidential. HIV tests are labeled only with a number code, and HIV testing is not explicitly documented in the medical chart.

Wesleyan University Davison Health Center

Wellness and Sexual Health Pre-Visit Survey

The questions herein will help us tailor our care to your interests and needs. Any questions that are not applicable or that you would prefer not to answer may be left blank. You may choose to discuss questions you don't answer. All information given is CONFIDENTIAL, for clinical use only, and cannot be released without your written permission except as required by law.

Preferred Name: _____ Pronoun: _____ Legal Name: _____
Box# _____ Address during breaks _____
Best way to contact you: _____

Do you have a specific concern you intend to discuss during your visit? Yes No
If yes, please describe _____

Wellness Inventory

The following is a list of common health issues. Please circle any that concern you.

HPV/genital warts	Arousal/Orgasm	Alcohol/Drugs	Cutting/Self harm
Other Sexually Transmitted Infections(STI)	Sexual orientation	Tobacco use	Grief/Loss
Questions about safer sex practices	Gender identity	Harassment	Racism
Contraceptives/Birth control	Finances	Abusive relationships	Gambling
Anatomy and sexual function	Academics	Stalking	Cancer screening
Relationship formation/maintenance	Sleeping difficulties	Sexual assault	Disordered Eating
Stress and relaxation techniques	Nutrition/Weight	Anger management	Pregnancy
Sports injuries/performance	Depression/Anxiety	Impulse control	Abortion

Details: _____

General Medical History

Have you ever been admitted to the hospital? If yes, for what reason? _____

Describe any surgery you have had. _____

List any current medical problems. _____

List all medications you take at least once a week. _____

Do you take calcium supplements? _____

Did you have two or more blistering (not just peeling) sunburns before age 18? _____

Have you, your parents or siblings had abnormal moles or skin cancer? _____

Has your cholesterol level ever been checked? If so, what was the value? _____

Do you, your parents or siblings have diabetes? _____

When was your last dental check-up? _____

What percentage of the time do you wear a helmet when biking/skating/roller blading? _____%

When you are in a front seat of a vehicle, what percentage of the time do you wear a seatbelt? _____%

How often do you engage in cardiovascular exercise (not weight lifting) for at least 20 minutes? _____

How many cups of caffeinated beverages do you drink per day? _____

Do you smoke or use tobacco? How much? For how many years? _____
Do you use alcohol? If yes, what type, how much, and how often? _____
On average, how many days per week do you get high? _____
What (if any) stimulant/mood altering drugs do you use? _____
Have you used Ritalin, Vicodin or other prescription drugs? _____ Have
you used performance-enhancing drugs or substances? What type? For how many years? _____

Gender Identity History

If you feel it would contribute to the quality of care we provide, please describe your gender identity history:

Would you like a copy of our Transgender resource/referral list? Yes No

Sexual History

Have you previously had a sexual health exam/testing or counseling visit? If yes, most recent date: _____

Have you been diagnosed with, or been concerned that you might have, any of the following (circle)?

Herpes

Genital/Venereal warts (HPV)

Gonorrhea

Chlamydia

Trichomoniasis

Syphilis

HIV/AIDS

Hepatitis A, B, or C

Yeast infection/balanitis

Bacterial Vaginosis

Frequent UTI

Details: _____

As part of the visit, we will need to ask explicit questions about your sexual history. Please take some time to review the number of partners you have had and the kind of sex you have had with them. Of particular relevance is the number of different partners with whom you have had unprotected oral, vaginal, or anal intercourse including with digits or sex toys.

During what percent of sexual episodes are you under the influence of drugs or alcohol? _____%

During what percent of sexual episodes is your partner under the influence of drugs or alcohol? _____%

Have you ever caused a pregnancy or become pregnant? If yes, what was the outcome of the pregnancy?

Is there anything else you feel we need to know? _____

Reviewed by: _____ Date: _____