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 <u>two</u> hours of the urethra's being flushed with urine.

- ☐ Review the document *Sexual Health Services at Davison Health Center*. 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) and prices if not filing to insurance
HPV	History and physical exam. Pap smear if indicated ($84.20, an additional fee applied for HPV typing if abnormalities are detected).
Herpes (genital)	History and physical exam. Swab test of skin outbreak (cost varies by test), an additional fee 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 ($38.25).
Gonorrhea	Swab or urine specimen depending on exam/anatomy ($38.25).
HIV	Blood test ($33.18).
Syphilis	Blood test ($14.72).
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). We prescribe and deliver (but do not stock) DepoProvera injections. Condoms are provided free.

Tests are billed directly to private and university-sponsored insurance unless student prefers to pay out of pocket. Fees can be charged to the student account as a Miscellaneous Lab Fee. Test results are discussed in a follow-up visit (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.

HEALTH HISTORY – WESLEYAN HEALTH CENTER (For Bodies with a Penis)

The Health History is personal and confidential. Please feel free to leave questions blank if you are uncomfortable answering. Be prepared to discuss with clinician.

Preferred Name	**Legal Name**	**Pronoun**	**Date**
Date of Birth	**Age**	**Semester Status**	
School Address		**School/Cell phone**	
Address during breaks		**Phone during breaks**	
Reason for Visit			

1. ALLERGIES (*Medications, foods, latex, etc.)*
❑None ❑Yes (Please list)

2. MEDICATIONS: (*Include herbal/vitamin/nutritional supplements)*

3. MEDICAL HISTORY - FAMILY MEANS IMMEDIATE FAMILY ONLY
(Check appropriate box)

❑ **Adopted – family history not known**

Have you or family member had:

	YOU	FAMILY
Heart disease	❑	❑
High blood pressure	❑	❑
High cholesterol	❑	❑
Migraines	❑	❑
Stroke	❑	❑
Blood clots	❑	
Anemia or blood disease	❑	❑
Diabetes	❑	❑
Thyroid disease	❑	❑
Liver disease	❑	❑
Mononucleosis	❑	❑
Depression	❑	❑
Eating disorder (anorexia/bulimia)	❑	❑
Other psychiatric disorders	❑	❑
Cancer	❑	❑
Birth defects or Inherited disease	❑	❑
Kidney or bladder problems	❑	❑
HIV/AIDS	❑	❑
Chlamydia	❑	❑
Gonorrhea	❑	❑
Herpes	❑	❑
Syphilis	❑	❑
Genital wart virus (HPV)	❑	❑
Physical/sexual abuse	❑	❑

❑ **NO KNOWN MEDICAL PROBLEMS**

HOSPITALIZATIONS/SURGERIES:

_____

_____

4. IMMUNIZATIONS

Have you ever had HPV vaccine? ❑No ❑Yes #1 ____ #2 ____ #3____

5. CONTRACEPTION HISTORY (*Check all that apply)* ❑Not Applicable
❑Abstinence
❑Condoms
❑Spermicides
❑Withdrawal of penis (before ejaculation) without contraception
❑Method now using _____
❑Partner on contraception

6. LIFESTYLE (*Check all that apply)*
Alcohol ❑None ❑Yes, type & amount per week _____
Nicotine:
(tobacco or vaping) ❑None ❑Yes, type & amount per day _____
Caffeine drinks ❑None ❑Yes, type & amount per day _____
Street drugs ❑None ❑Yes, type & amount _____
Do you exercise regularly? ❑No ❑Yes, type and amount _____

Have you <u>ever</u> had <u>any</u> sexual activity? ❑Yes, *answer all questions* below ❑**No**

Partner(s) gender(s) _____

Have you had ❑Oral sex ❑Anal receptive ❑Anal insertive ❑Vaginal intercourse sex

How old were you when you first had intercourse? _____years old

About how many sexual partners have you had in past 12 months?_____

Is sex painful for you? ❑No ❑Yes

Do you practice safer sex? ❑No ❑Yes

When was your last sexual contact or intercourse? _____

Have you ever had sex contact outside of the U.S.? ❑No ❑Yes

Partner with past/current STI? ❑No ❑Yes

Have you ever paid or been paid for sex? ❑No ❑Yes

When was your last STI screen? _____ What testing did you have done?

_____

_____

Clinician reviewed _____
initials / date

Name _____ **DOB**_____

Signs/Symptoms	Duration/Description
Asymptomatic	
Discharge from penis	
Discharge from rectum	
Burning with urination	
Genital lesion	
Lesion outside of genitalia	
Genital rash	
Rash elsewhere on body	
Other concerns	

Primary Reason for Visit _____

T BP Wt Ht Date _____

	Nl.	Var.	NE		Nl.	Var.	NE		Nl	. Var.	NE		Nl.	Var.	NE		Nl.	Var.	NE
SKIN	O	O	O	NECK	O	O	O	LUNGS	O	O	O	HEART	O	O	O	LYMPH NODES	O	O	O
HEENT	O	O	O	THYROID	O	O	O	CHEST	O	O	O	ABDOMEN	O	O	O	EXTREMITIES	O	O	O

Exam	Findings
General appearance	

Penis	
Scrotum	
Testes	
Inguinal hernia	
Anus/Perianal	
Rectum	

A: Assessment:

Plan: HPV testing
Chlamydia / Gonorrhea
VDRL / RPR
HSV
HIV / personal health
Hep C

Education:
Intimate Partner Violence
Contraception Risk / Use / Benefit
Substance Use / Abuse
STI / Safer Sex

Vaccines:
HPV
Hep A
Hep B

Rx:

RTC:

Clinician's signature: _____

Revised 01/23