

# Questions prior to STI testing

Name \_\_\_\_\_

Personal identity number \_\_\_\_\_

Mobile phone number \_\_\_\_\_

1. Why do you want a consultation/test? To

- make sure
- Complaint
- Informed by partner
- Contact tracing

2. You have a

- Penis
- Vagina
- .....

3. Your sex partner/partners has/have

- Penis
- Vagina
- .....

4. What type of sex have you had in the past year?

- Anal
- Oral
- Vaginal
- Other

Ja Nej

|   | Ja | Nej |
|---|----|-----|
| 5. Complaint?   |    |     |
| Urinary tract/pain when you urinate   |    |     |
| Discharge   |    |     |
| Intermenstrual bleeding   |    |     |
| Bleeding in connection with sex   |    |     |
| Pain in the lower abdomen/genitals/scrotum  |    |     |
| Cuts, rash, blisters, itching in the genitals/scrotum/anus  |    |     |
| Sore lymph nodes  |    |     |
| Eye complaint   |    |     |
| Throat complaint  |    |     |
| 6. Have you during the past year had anal, oral or vaginal sex with a new or temporary partner? The sexual history of the partner is significant. |    |     |
| 7. Have you had sex abroad? Some STIs may be more common in other countries   |    |     |
| 8. Would you like information about how to protect yourself?  |    |     |
| 8. Do you have any questions regarding your sexual health?  |    |     |