SEXUAL HISTORY
WHY, WHO, WHEN, HOW

Carrie Horwitch MD, MPH, MACP
AETC

Disclosures

- No disclosure to report
- Picture slides are from Internet sites-please do not reproduce. They are for education purposes only.

Objectives

- Discuss Why to take a sexual history
- Discuss Who should have a sexual history
- Determine when to take a sexual history
- Be able to take a sexual history

Definitions

- Sexual orientation or sexual preference: who a person is romantically /sexually attracted to

- Gender identity: internal sense of self and how they fit in world from perspective of gender

Epidemiology: International

- >500 million with HSV
- 82 million cases of GC
- 129 million cases of Chlamydia
- 7.1 million cases of syphilis
- >300 million women with HPV
- >200 million with Hepatitis B
- 37.7 million living with HIV, 1.5 million new infections annually
- Source: WHO 2020 data

United States Data 2024

Chlamydia: 1,515,985

Gonorrhea 543,409

Syphilis (prim & secondary): 190,242

Congenital Syphilis 3941

Source: CDC

Washington State 2024 data

- Chlamydia: cases 26, 183
- Gonorrhea: cases 9470
- Syphilis: cases 1083
- Congenital syphilis: 81
- HIV: cases 408 (end of 2023 data)

- Source: WA Dept of Health

Why take a sexual history?

- Part of the general preventive care exam
- Preventable diseases and treatable conditions
  - Many infections are asymptomatic
  - Common cause of morbidity and mortality
- Opportunity for safe sex and contraception education
- Identifies those at risk for STDs including HIV
- Partner notification
- Discover issues of sexual (dys)function
- Discover issues of prior or current abuse

Prevention of STDs

- Abstinence or delay in age of first contact
- Condom use
- HPV vaccination
- HAV, HBV vaccination
- STD screening-treat asymptomatic pts/partners
- HIV testing
- PrEP-pre-exposure prophylaxis for HIV
- Doxy-PEP- prevention of GC, Chly, Syphilis

The average % of MDs that take a sexual history?

- A. 5-15%
- B. 20-35%
- C. 50-65%
- D. >75%

Barriers to sexual history

- Not seen as relevant
- Inadequate training
- Embarrassment
- Fear of offending patient
- Time constraints
- Too personal

Who should have a sexual history?

- Anyone who has not had sex yet?
  - Remember adolescents/teens are at increased risk of STIs/HIV
  - Can do both STI and contraception prevention
- Anyone who is currently having sex?
  - Test appropriately
- Anyone who has ever had sex?
  - Age should not limit your taking a sexual history
  - Being married/single/widowed/divorced is a social history it is not a sexual history

Case One

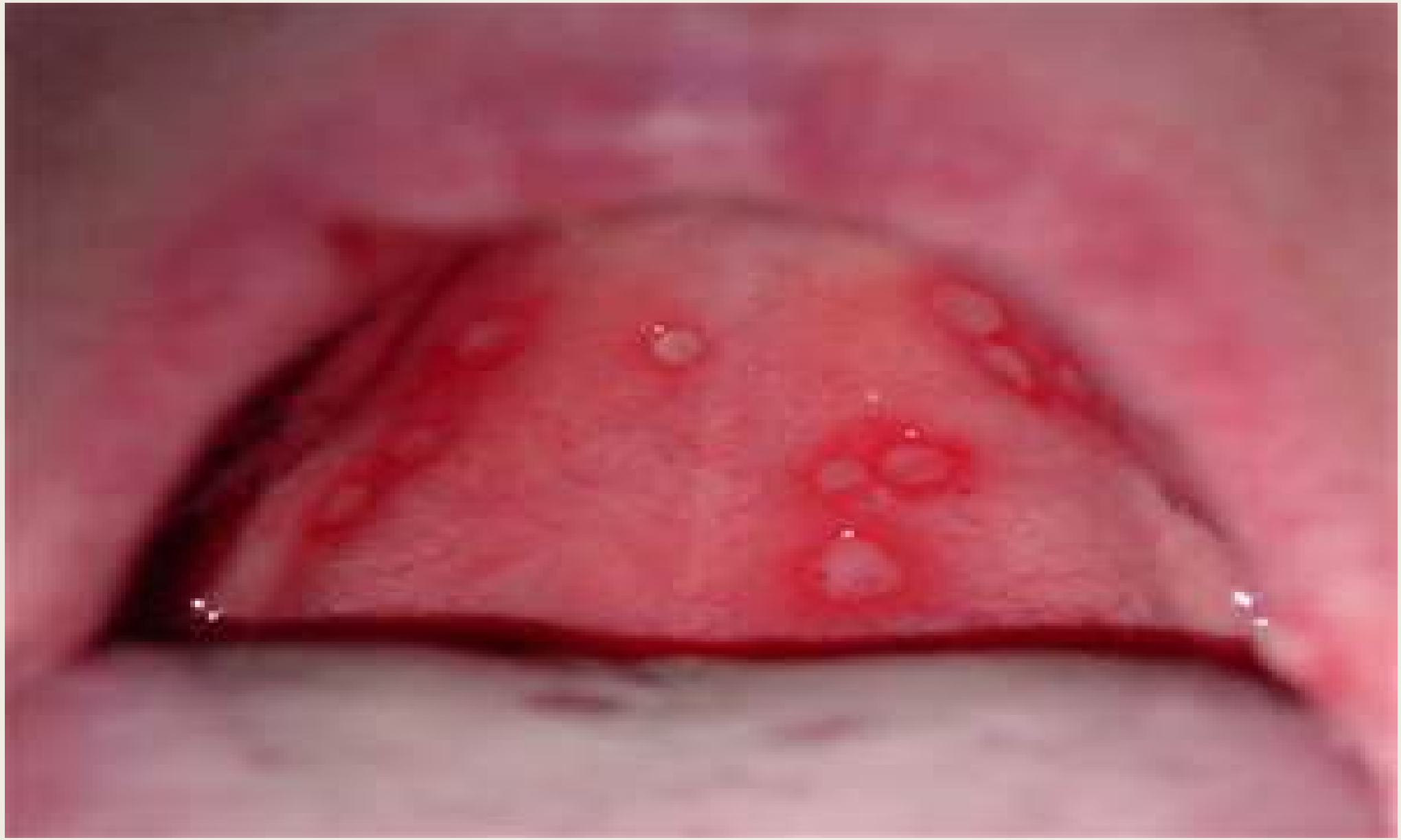
- 73 yo widowed male presents to the hospital with fever, worsening shortness of breath. PMH: CAD, CHF
- Meds: ASA, metoprolol, simvastatin, ace inhibitor, PPI
- SH: nonsmoker, no alcohol, no illicit drug use, widowed 3 yrs
- T 38.5 BP 130/90 HR 90, pt looked unwell, lungs with rales, mild pitting edema, faint rash on upper chest
- Labs: BNP elevated, trop neg, cbc/cmp/ lactate nl,
- CXR: mild pulmonary edema, no infiltrates
- Rapid influenza and Covid negative

Who needs sexual histories? Examples of clinical presentations of STIs

- Acute mononucleosis
- Fatigue
- Fevers
- Rashes/skin lesions
- Pharyngitis
- Diarrhea
- Arthralgias/Arthritis/vasculitis
- Abdominal pain
- Hearing loss
- Weight loss
- Dementia
- Vision Loss
- Hair loss
- Renal insufficiency
- Elevated liver function tests
- Neuropathies
- Cardiomyopathy
- Sexual function concerns: ED, vaginal dryness
- Genital lesions or discharge
- Pelvic pain
- Abnormal PAP

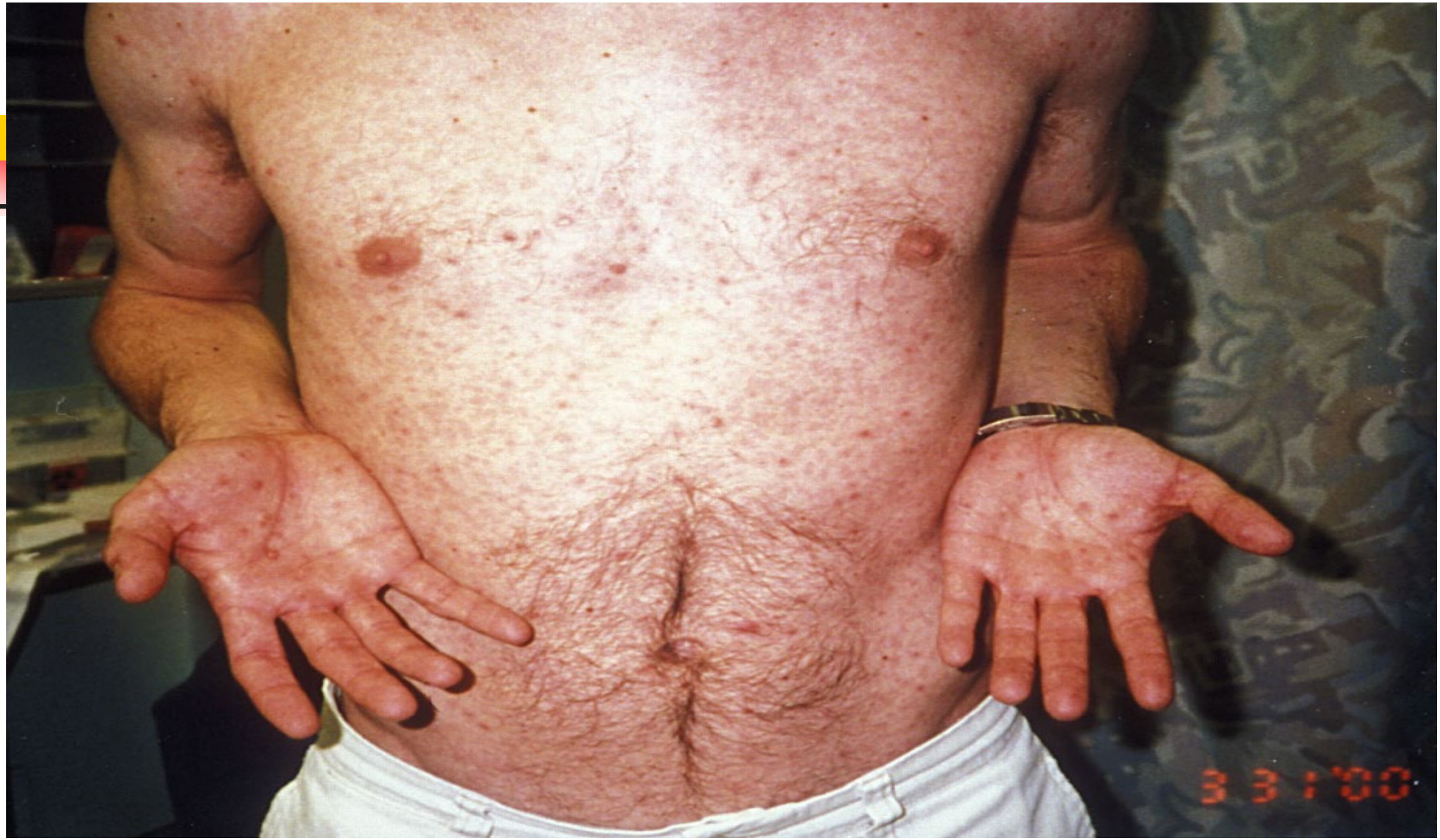
Case 2

- 41 yo married man comes to clinic with his wife. He is c/o sore throat and low grade fever. He says he is monogamous with his wife
- PE: T 99F
- Pharynx has ulcer, mild cervical lymphadenopathy



Case 3

- 32 yo male presents w/2 day h/o blurry vision, floaters and occ blue tint to his vision. No fevers, chills, no rashes. Pt is seen in clinic and had normal looking eye exam. No other findings noted. He was seen by Ophthalmology and no acute findings were noted. No testing was done
- Pt returned one week later with rash and vision getting worse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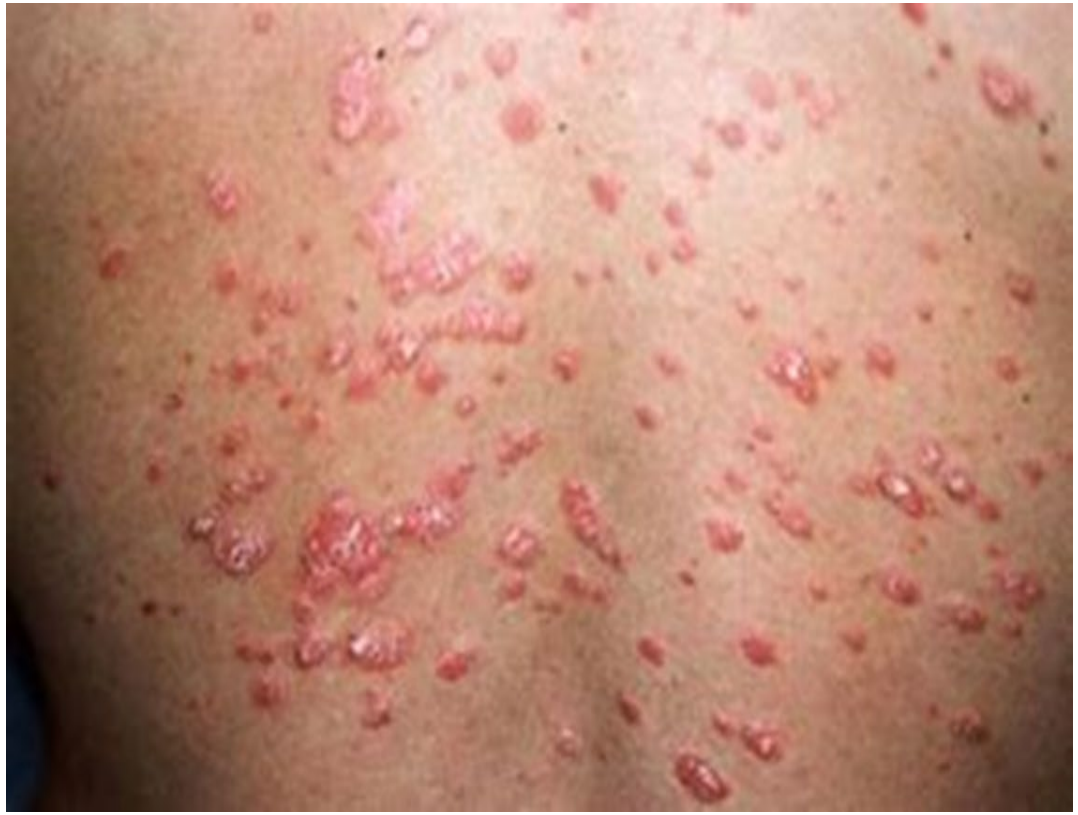
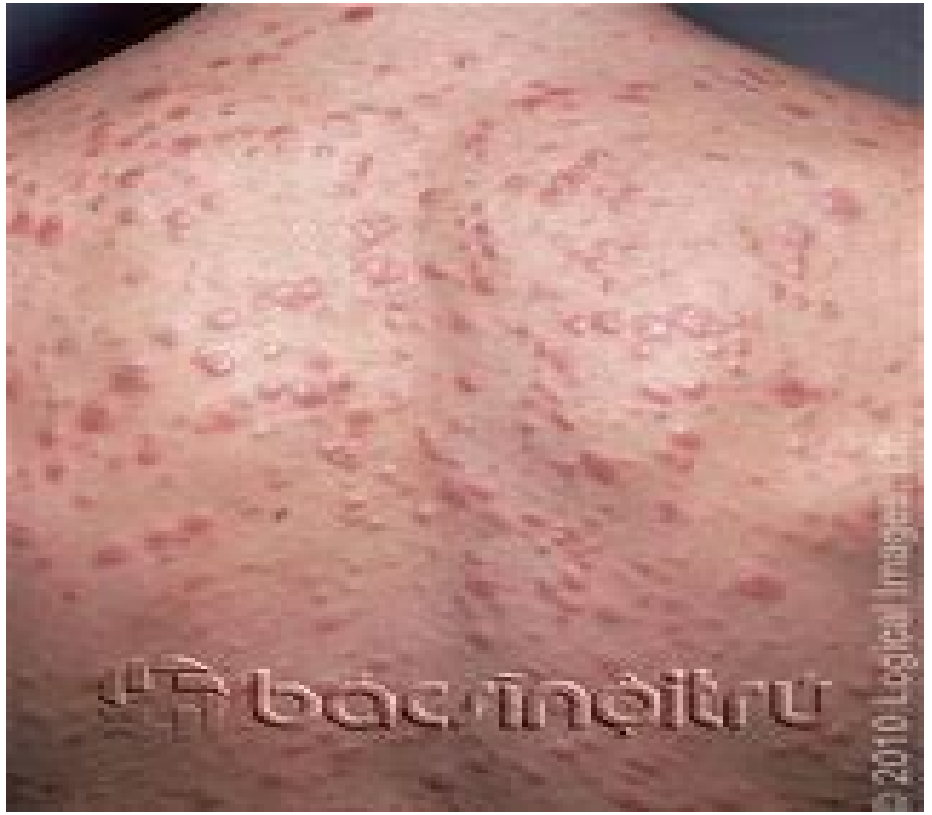
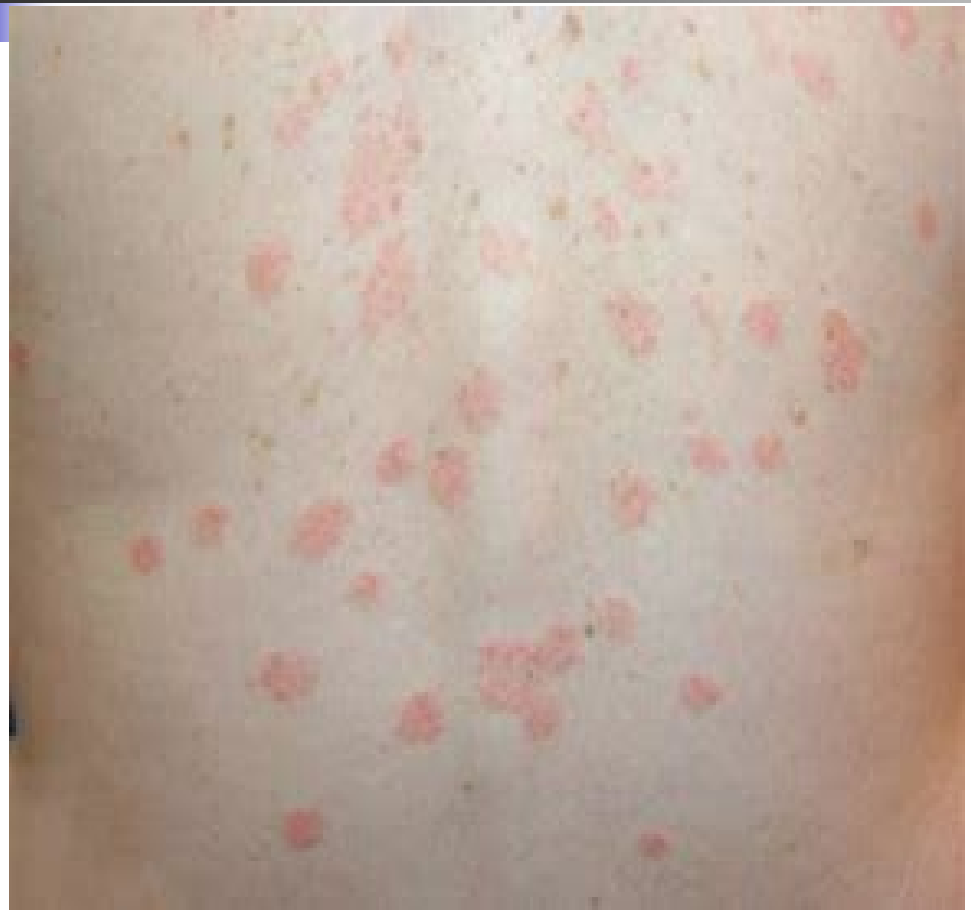
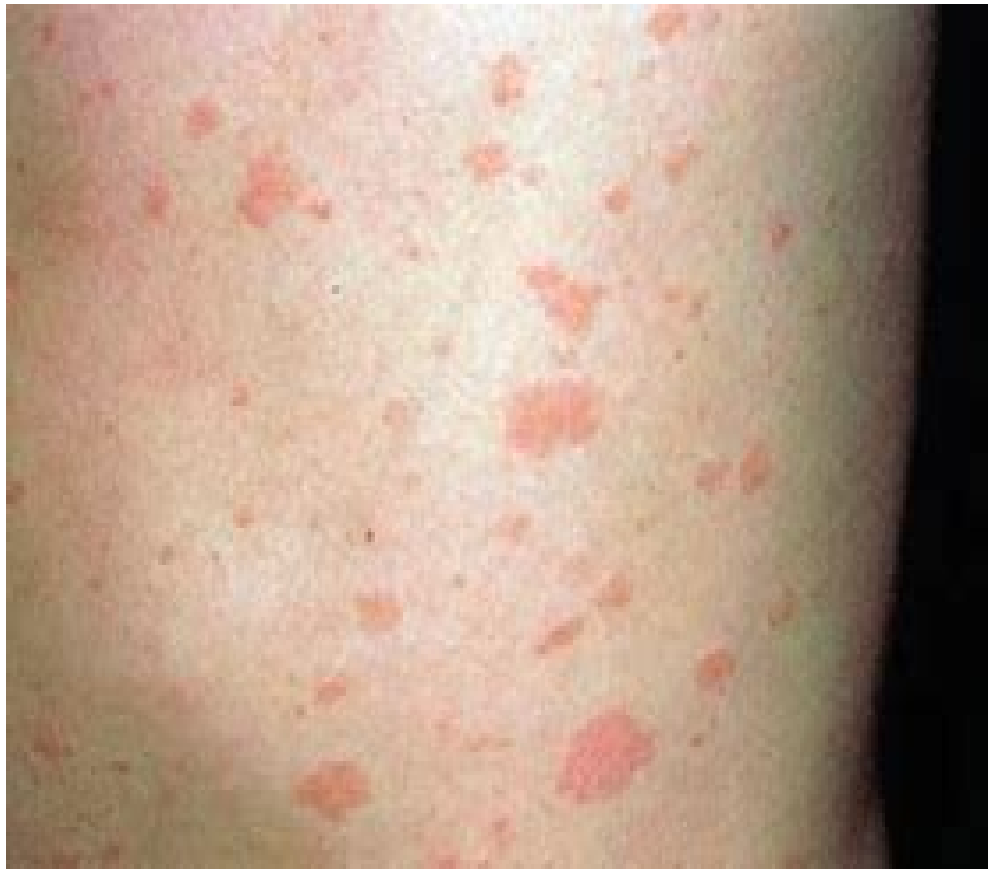
Psoriasis vs syphilis ?





Pityriasis rosea vs syphilis?





Case 4

- 25 yo male c/o redness and discharge from the eye x 1 day. No past h/o STD
- Pt had new sexual contact 10 days ago including oral sex with female partner
- PE: afebrile
- Exam: notable for erythematous conjunctiva with discharge noted


Online Journal of Ophthalmology - www.onjoph.com

When to take a sexual history

Which of the following has been shown to be the best time to take a history?

- A. Annual preventive exam
- B. Any visit with clinician
- C. During the social history portion
- D. During the review of systems
- E. During the clinical exam

When to take a sexual history?

- When it is most appropriate and comfortable for the clinician and patient

Sexual history-key information

- Partners-current and past
- Practices: oral, rectal, vaginal, etc
- Prevention of pregnancy
- Protection from STDs-condoms, PrEP
- Past history of STDs-could include hepatitis B or C
- Sexual (dys)function
    - Source: CDC

Before any sexual history questions

- Introduce yourself
- Ask patient to introduce themselves
- Patient should be clothed (especially if first time visit)
- Agenda setting for patient concerns for that visit
- Patient should be alone in room
- Maintain professional verbal and non-verbal communication

Which is the most reliable question for assessing sexual risk behavior

- A. Are you sexually active?
- B. Are you in a mutually monogamous relationship?
- C. How many partners have you had?
- D. I have no idea

The Problem

- No studies to show the “best” questions to ask for a sexual history
- No studies to show which questions lead to the most accurate response
- Students and residents do not observe attendings taking sexual histories

Role Play

Suggested history questions

- Do you have any questions/concerns about sexual function that you want to discuss?
- Have you ever had sex?
- Do you currently have a sexual partner (contact)?
- Have you had a new sexual contact in past…mo/yr
- Do you have any sexual contacts outside of your stable relationship?
- Are your partners male body/female body or both?
- Do you engage in oral sex? Rectal sex? Vaginal sex? (or alternative what body parts do you use for sex?)
- Questions may need to be modified for cultural appropriateness

Examples of stigmatizing language

- Gay
- Bi
- Risky sex
- Lesbian
- Transgendered
- High risk behavior
- “alleged”
- Top or Bottom
- Adultery
- Drug user
- Prostitute
- Addict
- Swinger

- What words do you find contribute to bias?

Caveats to sexual history taking

- Always be respectful-cultural competence
- Always Be Non-judgmental, no moralizing
- Make no assumptions
- Use Ask..Listen approach
- Professional verbal and non-verbal communication
- Don’t type into computer when getting history
- Ensure record is confidential
- At one visit get lifetime history
- Follow up visits can get interim history

Take Home Points

- Sexual history is as important to our patients health as smoking/alcohol/drug use/medications etc
- STIs can present in many forms
- Everyone should have sexual history taken
- Respect patients preferences
- Be mindful of cultural differences
- The more the clinician practices this skill the easier it becomes