

## **STI Self-Testing Questionnaire**

Name.....

DOB.....

- This method of testing is for people with **NO** current STI symptoms
- If you have symptoms of an STI or you have been informed by a partner that they have an STI, please arrange an appointment with a nurse as you may need to start treatment straight away
- This form is only for patients registered with the University Health Centre
  - Domestic registered student – CSC no charge, or \$15
  - International registered student – fee \$40 and cost of swab/blood test
  - Non registered patients can make an appointment with your own GP or go to the Sexual Health Clinic or Family Planning (you may be able to be seen at the UC Health Centre if we have enough capacity – please check with reception).

### **CURRENT STI SYMPTOMS**

*(If you answer "YES" to any of the first 4 questions you need to make a Doctors appointment)*

Do You have discharge/drip/abnormal blood spotting from vagina, penis or anus?	YES/NO
Do you have sore(s) or a rash on penis, vagina or anus or body?	YES/NO
Do you have pain/discomfort when passing urine (peeing)?	YES/NO
Do you have pain/discomfort in lower tummy, anus or genital area?	YES/NO
<b>RISKS</b>	
Has a sexual partner told you they have a sexually transmitted infection (STI)?	YES/NO
When was your last STI check: never/3 months/6 months/1 year/over a year/other .....	
Number of partners since your last STI check? .....	
Number of partners in the last: 3 months..... 1 year.....	
Do you use condoms with casual partners? Always/Sometimes/Never	
Would you like a pack of condoms	YES/NO
Have you ever given oral sex?	YES/NO
Have you ever received anal sex?	YES/NO
Have you ever used needles to inject drugs or had a tattoo from an unlicensed source?	YES/NO
Has a previous partner ever injected drugs or had a tattoo from an unlicensed source?	YES/NO
Would you like a blood test for blood borne virus* (HIV, syphilis, hepatitis)?	YES/NO
Would you like info on PrEP HIV prophylaxis(male/transgender people with partner with penis)	YES/NO
Have you ever had a sexual encounter against your wishes or sexual abuse?	YES/NO
Have you experienced domestic violence (psychological/sexual/physical)?	YES/NO
If you have answered yes, would you like us to contact you to provide support	YES/NO
Do you smoke cigarettes?	YES/NO
If you smoke cigarettes, do you want to stop?	YES/NO

\*Info about the infections/tests <https://www.canterbury.ac.nz/healthcentre/our-services/sexual-health/>

**Please leave the completed form at reception or you can photo/scan the form and email to [Dutynurse@canterbury.ac.nz](mailto:Dutynurse@canterbury.ac.nz)**

This form will be processed within 48 hours.

We will **text/email** you when your test kit is ready to be collected from reception.

We will contact you by **text** with a negative result

We will contact you by **phone/email** with a positive result or if you need to come in for an appointment.

I want to be contacted on:

This phone number.....or this email address.....

**Confidentiality:** we are here to listen not tell. The only reason we might have to consider contacting another service or professional without your permission would be to protect you or someone else from serious harm and we would always try to discuss this with you first.