



2013 UK national guideline for consultations requiring sexual history taking

Clinical Effectiveness Group
British Association for Sexual Health and HIV

Gary Brook¹, Lesley Bacon², Ceri Evans³, Hugo McClean⁴,
Colin Roberts⁵, Craig Tipple⁶, Andrew J Winter⁷ and
Ann K Sullivan⁸

New in the 2013 Guidelines

This guideline is an update of a previous version published in 2006. In this new version, we have reflected changes in the way sexual health services are now provided by adding an expanded section on integrated STI/contraception services and a new section on outreach services. We have also expanded the sections on electronic patient records and the use of technology in sexual history taking. The other sections have been updated to reflect new evidence and practice.

Introduction and methodology

This guideline is an update of the guideline published in 2006 and, like its predecessor, provides guidance for best practice in consultations requiring sexual history taking. It is primarily intended for use in UK Genitourinary Medicine (GUM)/Sexual Health settings, but can be applied or adapted for use in other settings where sexually transmitted infection (STI) assessments are undertaken such as in integrated STI/contraception sexual health services and other specifically commissioned services, including general practice. This guideline is for use by all healthcare professionals (doctors, nurses and health advisers) and for use when dealing with patients who are attending with symptoms that may be attributed to a STI, with concern about STIs or are requesting screening for STIs. It will also be useful to managers and commissioners of sexual health services in understanding service needs.

Unlike other Clinical Effectiveness Group guidelines, this is not a tool for decision-making after establishing a diagnosis; rather, it describes best practice for establishing the facts on which clinical decision-making is based.

The purpose of the guideline is to help improve the sexual health of individuals attending GUM and integrated sexual health clinics by encouraging high

standards of sexual risk assessment. The guideline offers recommendations on best practice regarding sexual history for both men and women, including adolescents.

In reading these guidelines, it should be understood that the content and detail of the sexual history will depend on the setting in which it takes place, the role of the clinical service and the needs of the individual patient.

The guideline is predominantly based on what a broad range of clinicians believe constitutes reasonable best practice. Because of the limited evidence regarding best practice in sexual history taking in GUM clinic settings, evidence is sometimes cited from non-UK sexual health settings and from other settings outside sexual health care where necessary.

Search Strategy

A literature search was undertaken using the terms 'sexual history', 'sexual history-taking' and 'sexual risk assessment' on Medline and Pubmed databases from January 2006 to July 2012. In addition, sections on sexual history taking in relevant British Association for Sexual Health and HIV (BASHH) and other guidelines were reviewed for other references. Forward and

¹North West London Hospitals NHS Trust, London, UK

²Lewisham Healthcare NHS Trust, London, UK

³Chelsea and Westminster NHS Foundation Trust, London, UK

⁴City Health Care Partnership, Hull, UK

⁵John Hunter Clinic, Chelsea and Westminster NHS Foundation Trust, London, UK

⁶Imperial College Healthcare NHS Trust, London, UK

⁷NHS Greater Glasgow and Clyde, Glasgow, UK

⁸Clinical Effectiveness Group, British Association for Sexual Health and HIV, London, UK

Corresponding author:

Gary Brook, Patrick Clements Clinic, Central Middlesex Hospital, North West London Hospitals NHS Trust, Acton Lane, London NW10 7NS, UK.

Email: gary.brook@nhs.net



NICE has accredited the process used by BASHH to produce its European guideline for consultations requiring sexual history taking. Accreditation is valid for 5 years from 2013. More information on accreditation can be viewed at www.nice.org.uk/accreditation

backward searching from key references was also conducted.

Piloting and Feedback

The Writing Committee includes GUM clinicians and representatives from the Faculty of Sexual and Reproductive Health (FSRH), nursing and Sexual Health advising. Prior to publication, the final draft of the guideline was placed on the BASHH website for a three-month consultation period, and copies were circulated to the Genitourinary Nurses Association (GUNA), the Society of Sexual Health Advisers (SSHA) chairs and the FSRH for comment and peer review. It was also reviewed by the BASHH Public Panel. This guideline was piloted before it was finally ratified.

Contents

1. Confidentiality
 - 1.1 General medical confidentiality
 - 1.2 The sexual health clinic and confidentiality
 - 1.3 The environment for sexual history taking
 - 1.4 Management of sexual contacts
2. Communication
 - 2.1 Clinic access and external communication/advertising
 - 2.2 Communication skills
 - 2.3 Communication difficulties
3. Components of a sexual history
 - 3.1 Reasons for attendance
 - 3.2 Symptom review
 - 3.3 Sexual history
 - 3.3.1 Last sexual contact
 - 3.3.2 Previous sexual partner
 - 3.3.3 Look-back interval for recording information about partners
 - 3.4 Other components of history
 - 3.5 Contraceptive and reproductive health history
 - 3.6 The integrated contraception and sexual health service
 - 3.7 Risk assessment for blood-borne viruses
 - 3.8 Closing the sexual history
4. Documentation
 - 4.1 General principles
 - 4.2 The use of standard history proformas
 - 4.3 Electronic patient records
 - 4.4 Computer-assisted interviews
5. Specific circumstances
 - 5.1 Seeing patients who are under the age of 16 years
 - 5.2 Taking a sexual history in the outreach setting
6. Applicability
7. Resource implications
8. Auditable outcomes

References

Appendices

I. Confidentiality

I.1. General medical confidentiality

All National Health Service (NHS) employees are expected to adhere to the Caldicott Principles for confidentiality and the guidance from the General Medical Council and Nursing and Midwifery Council, which stress the importance of confidentiality.¹⁻³ General health confidentiality in the UK is a common law duty. The duty of confidentiality to the patient is absolute except in very specific circumstances, such as when it is in the patient's or public's interest. This might include child protection cases, or cases where another individual is placed at risk of an infection. Some infections that may be diagnosed in sexual health and HIV clinics (such as infectious hepatitis and infectious bloody diarrhoea) may require statutory notification. In Scotland, notification for hepatitis and shigella is usually made by the diagnosing laboratory.⁴⁻⁶ Appendix 1 is an example of detailed information for patients about how their information is dealt with. Services may wish to distil this into brief statements for inclusion on web sites, leaflets, etc.; the full leaflet may be useful for patients with particular concerns. There is also a link to an easy-read version at the end of Appendix 1.

I.2. The sexual health clinic and confidentiality

The particular vulnerability of patients attending a clinic that tests for or treats STIs is reflected in several statutory regulations. A duty of enforcement of confidentiality originates from The Public Health (Venereal Diseases) Regulations 1916⁷ and has been sequentially updated in legislation.⁸ The NHS Code of Confidentiality¹ applies to services managing STIs in England and Wales, with an additional duty of enforcement of confidentiality required by the NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000, although there is no similar legislation in Scotland or Northern Ireland.⁹ This means that services managing STIs must operate systems for clinical record management that does not allow disclosure and where identifying information is not shared except for the purpose of treatment of STIs, or for the purpose of prevention of infection.

In practice in UK sexual health clinics, medical practitioners such as the GP or other health care workers are not routinely informed of a patient's attendance for STI testing, unless the patient has been initially referred

by letter or the patient consents to such communication. It is good practice to seek consent to inform GPs of diagnoses or procedures that may have longer-term health implications (e.g. male or female sterilisation, skin biopsy, HIV and syphilis). Cervical cytology may be undertaken as part of a national screening programme and the results should be available to GPs. If it is in the patient's interest for another health care worker to be informed, their consent to disclosure should be sought. Care should also be taken to ensure that the results of tests taken in a sexual health service are not viewable in a way that the patient can be identified by others on an electronic results browser/viewer unless specific consent to communication has been granted.

1.3. The environment for sexual history-taking

A welcoming, comfortable, confidential physical environment is likely to encourage openness and candour when discussing sensitive issues, such as sexual behaviour^{10,11}. To facilitate this, the following measures should be adopted:

- Services may find that clearly displaying literature that stresses confidentiality of the clinic and the non-judgemental nature of assessment improves the consultation;
- Clinic administration procedures (storage/visibility of clinic files and clinic lists, etc.) should be designed to ensure that confidentiality is maintained between patients;
- Clinics should decide on the most appropriate way of calling patients for consultations such as calling by first name, full name or clinic number. Care should be taken to confirm that patient identification is correct;
- Consultations should take place in private settings and in a soundproof room.¹²;
- Students and observers should be present only with the patient's consent, and the wishes of the patient should be respected if the presence of a student or observer is declined.¹¹ However, the patient should be offered a chaperone for any intimate examination.^{10,13}
- Requests for clinician gender on the basis of culture, religion or personal preference should be accommodated where possible and pathways to other services should be in place to support patients whose preferences cannot be accommodated.

Recommendation: Sexual history taking should take place in a confidential, private environment (IV, C).

Recommendation: All clinics should have a confidentiality policy that should be displayed in the waiting area or otherwise made available to patients (IV, C).

Recommendation: All patients should be offered a chaperone for any intimate examination in accordance with GMC guidance IV,C.

Recommendation: All patients should be offered a clinician of their preferred gender where possible IV,C.

1.4. Management of sexual contacts

The utmost care should be taken to preserve the confidentiality of patients and their sexual contacts during the consultation. This can be difficult in certain situations; for example, where a patient attends as a contact of an infection but does not know the reason for their attendance.¹⁴ The index patient must not be identified. The clinician must not confirm the identity of the index patient, even if raised by the patient, or reveal any details about their attendance (or non-attendance) or clinical condition. Care should also be taken to avoid having third-party information in a form that might be easily viewable on an electronic patient record (EPR) in case a patient might see this on the computer screen.

2. Communication

2.1. Clinic access and external communication/advertising

Although many patients who are referred to or refer themselves to sexual health/GUM clinics will expect to be asked sensitive questions regarding their sexual behaviour, this may not always be the case.

Clinic advertising, including the use of websites and clinic leaflets displayed elsewhere (e.g. GP surgeries, contraceptive clinics, schools, colleges, etc.), should explain the role of the clinic and what should be expected during a consultation. This may improve the acceptability of asking questions which may otherwise be perceived as being intrusive.

Recommendation: Clinic literature/advertising leaflets should include sections regarding the need to take an appropriate sexual history (IV, C).

2.2. Communication skills

The ability to communicate effectively is required of all clinicians and may be important in improving health outcomes.^{15,16} The initial contact with a patient can be particularly important for obtaining an accurate

sexual history and particular attention should be paid to:

- The initial greeting to the patient;
- Maintaining eye contact (if culturally acceptable) and using appropriate body language;
- Initiating a consultation with open questions followed by exploration of initial concerns and more closed questions as the consultation continues;¹⁶
- Explaining the rationale for some of the questions asked;
- Considering the use of sexually explicit language within the sexual history consultations and use language that is clear, understandable and with which both clinician and patient are comfortable;
- Awareness of the signs of anxiety and distress from the patient;
- Recognising non-verbal cues from the patient.

Particular issues that need to be covered in training clinicians in sexual history taking include addressing attitudinal issues of the clinician to sexual behaviour and specific knowledge about the range of sexual consultations that can be undertaken.¹⁷

Although there are well-recognised models of best practice in communication skills training, assessment of the quality of communication skills is complex.^{18,19} A variety of different mechanisms for assessing communication skills have been proposed including patient questionnaires and direct or video-recorded consultation with patients or actors.

Recommendation: Assessment of clinician communication skills should form part of the assessment of service quality (IV, C).

2.3. Communication difficulties

All sexual health clinics should have policies in place to address the communication needs of specific patient groups, including patients whose first language is not English, people with hearing or learning difficulties and people who cannot read. Sign language interpreters, foreign language interpreters, access to telephone interpretation services, use of communication aids including websites, working with local support organisations and dedicated clinic times for patients with communication problems are all strategies that may need to be adopted.

Recommendation: All sexual health clinics should have policies in place to address the needs of patients with whom there are communication problems, including illiteracy (IV, C).

3. Components of a sexual history

The appropriate detail of the sexual history will vary between services but should allow:

- A careful assessment of symptoms to guide the examination and testing
- An exposure history to identify which sites need to be sampled and the STIs to which the patient may be at risk
- An assessment of contraception use and risk of pregnancy
- Assessment of other sexual health issues (also allowing a discussion of psychosexual problems)
- Assessing HIV, hepatitis B and C risk for both testing and prevention.²⁰
- Assessment of risk behaviours, which will then facilitate health promotion activity including partner notification and sexual health promotion

A summary of suggested sexual histories in different testing scenarios is given in Tables 1–4.

3.1. Reasons for attendance

It is best to start the sexual history with less intrusive questions regarding presenting concerns and symptoms before asking more sensitive questions regarding sexual behaviour. After the reason for attendance has been identified, the clinician should ask closed questions to identify specific GU symptoms. All clinicians will ask

Table 1. Minimum sexual history for asymptomatic patients attending for an STI screen.

- Confirm lack of symptoms
 - Date of LSC and number of partners in the last three months
 - Gender of partner(s), anatomic sites of exposure, condom use and any suspected infection, infection risk or symptoms in partners
 - Previous STIs
 - For women: last menstrual period (LMP), contraceptive and cervical cytology history.
 - Blood borne virus risk assessment and vaccination history for those at risk
 - Agree the method of giving results
 - Establish competency, safeguarding children/vulnerable adults
- Recommend/consider*
- Recognition of gender-based violence/intimate partner violence^a
 - Alcohol and recreational drug history^b

^aThis is a requirement in Scotland but not the rest of the UK.

^bAn alcohol history is recommended under NICE guidelines. NICE public health guidelines are recommended to be followed in England and are usually supported in the other UK countries. A recreational drug history is not a requirement under NICE or other public health guidance; however, certain groups such as MSM, young people may be at increased risk.

Table 2. Minimum sexual history for symptomatic female patient attending for STI testing.

- Symptoms/reason for attendance
 - Date of LSC, partner's gender, anatomic sites of exposure, condom use and any suspected infection, infection risk or symptoms in this partner
 - Previous sexual partner details, as for LSC, if in the last three months and a note of total number of partners in last three months if more than two
 - Previous STIs
 - Last menstrual period (LMP) and menstrual pattern, contraceptive and cervical cytology history
 - Pregnancy and gynaecological history
 - Blood-borne virus risk assessment and vaccination history for those at risk
 - Past medical and surgical history
 - Medication history and history of drug allergies
 - Agree the method of giving results
 - Establish competency, safeguarding children/vulnerable adults
- Recommend/consider*
- Recognition of gender-based violence/intimate partner violence^a
 - Alcohol and recreational drug history^b

^aThis is a requirement in Scotland but not the rest of the UK.

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Table 3. Minimum sexual history for symptomatic male patient attending for STI testing.

- Symptoms/reason for attendance
 - Last sexual contact, partner's gender, anatomic sites of exposure and condom use, any suspected infection, infection risk or symptoms in this partner
 - Previous sexual partner details as for LSC, if in the last three months, and a note of total number of partners in last three months if more than two
 - Previous STIs
 - Blood-borne virus risk assessment and vaccination history for those at risk
 - Past medical and surgical history
 - Medication history and history of drug allergies
 - Agree method of giving results
 - Establish competency, safeguarding children/vulnerable adults
- Recommend/consider*
- Recognition of gender-based violence/intimate partner violence^a
 - Alcohol and recreational drug history^b

^aThis is a requirement in Scotland but not the rest of the UK.

^bAn alcohol history is recommended under NICE guidelines. NICE public health guidelines are recommended to be followed in England and are usually supported in the other UK countries. A recreational drug history is not a requirement under NICE or other public health guidance; however, certain groups such as MSM, young people may be at increased risk.

further questions regarding the duration and nature of any reported symptoms.^{10,11} Some patients may report that a partner has an STI and it is important to clarify the nature of the infection and contact as accurately as possible.

3.2. Symptom review

It is uncertain whether a symptom review in patients not reporting symptoms is useful. However, many GUM clinicians ask about specific genital symptoms in case this reveals overlooked or ignored problems. Many clinicians would routinely ask women presenting to GUM clinics questions relating to the following symptoms:

- Unusual vaginal discharge
- Vulval skin problems
- Lower abdominal pain/deep dyspareunia
- Dysuria
- Unusual vaginal bleeding, including post-coital and inter-menstrual bleeding

Many clinicians would routinely ask men presenting to GUM clinics questions relating to the following symptoms:

- Urethral discharge
- Dysuria
- Genital skin problems
- Testicular discomfort or swelling
- Peri-anal/anal symptoms (in men who have sex with men (MSM))

Table 4. Additional history for a patient attending an integrated STI/contraception clinic.

In addition to the items in Tables 1–3, the following history may be taken in more detail if indicated.

For women

- Current contraception and any difficulties with the current method
- Identify unmet contraception need and pregnancy risk
- Abnormal vaginal bleeding
- Menstrual pattern and changes in pattern
- Mood changes with menstrual pattern
- Identification of unmet need with regard to difficulties with sexual performance and satisfaction
- Family history
- Smoking history
- HPV vaccination history

For men

- Contraception, including contraceptive use by female partners
- Identification of unrecognised lower urinary tract symptoms
- Identification of unmet need with regard to difficulties with sexual performance and satisfaction

3.3. Sexual history

The more detailed parts of the sexual history outlined below may be identified during the initial discussion with the patient. They will, however, more often be dealt with while asking more 'closed' questions later in the consultation.

Services primarily undertaking STI screening may undertake a brief core sexual history to establish whether someone is at any risk of STIs and take a more detailed history if the STI screen is positive.

Using 'bridging' questions, which link general life-style questions to sexual history questions or 'universal' questions (questions which are explicitly asked of all patients), may also help when introducing sensitive questions.²¹ The need to ask important questions regarding risk taking (such as same sex partners and injecting drug use), which some patients may find offensive, should be clearly explained to all patients.²²

It is important to ascertain the type of sexual contact/sites of exposure in both MSM and heterosexual men and women in order to be able to identify which sites need to be sampled. In women who report oral or anal sex, up to 25% of chlamydia or 35% gonorrhoea infection would be missed if the pharynx or rectum were not sampled, as infection may be found in these extra-genital sites only.²³⁻²⁶ In addition, a similar proportion of infection is present in both genital and extra-genital sites. Azithromycin is reported to be as little as 80% effective in eradicating extra-genital chlamydia infection with doxycycline being much more effective.^{27,28} Therefore, if extra-genital swabs are not taken from a person at risk, the infection may go unrecognised and untreated or the patient may be given inadequate antibiotic therapy. This would leave the patient still infected and acting as an infection source to partners as well as potentially being at risk from complications of the infection. A history of the types (sites) of sexual contact is also recommended in the IUSTI European guidelines for the organization of a consultation for STIs, 2012.²⁹

3.3.1 Last sexual contact. All individuals being assessed for risk of STIs should be asked about:

- The gender of partner(s).

Rationale: to identify MSM in order to offer rectal and pharyngeal samples, undertake hepatitis screening and vaccination.

- The type of sexual contact/sites of exposure (oral, vaginal, anal) *II A.*

Rationale: to identify which sites need to be sampled.

- Condom use/barrier use (and whether properly used).

Rationale: facilitation of condom promotion and risk assessment.

- The relationship with the partner (live-in, regular, casual partner, etc.), duration of the relationship and whether the partner could be contacted.

Rationale: to facilitate partner notification.

- The time interval since the LSC.

Rationale: to inform the patient of any need for repeat testing if still inside 'window' periods for infection detection and to help in assessing the need for emergency contraception or post-exposure prophylaxis for HIV infection.

- Any symptoms or any risk factors for blood-borne viruses in the partner including known or suspected STIs, injecting drug use, previous homosexual sex (for male partners) and any other risk of sexual infection.

Rationale: to identify STI or BBV diagnosis, or symptoms suggestive of an STI, in partners

3.3.2. Previous sexual partner, if less than three months previously (before partner of LSC, last partner change). All individuals should be asked about the:

- Gender of partner(s);
- Sites of exposure;
- Use of barrier methods;
- Relationship to partner (as for LSC);
- Symptoms or high-risk behaviour of this partner.

Rationale: this is the same rationale as for LSC.

3.3.3 Look-back interval for recording information about partners

- As a minimum, the sexual history should include a record of the number of partners within the previous three months and the last two partners if both were within the last three months.³⁰ Taking a three-month risk history would identify risk behaviour not covered by a negative syphilis and third generation HIV antibody test on the day of the consultation.²⁰ If no partners are reported during this

time, the last time the patient had sexual contact should be noted;

- If the patient is known, or suspected of having a particular STI, the look-back interval(s) in the BASHH Statement on partner notification for sexually transmissible infections should be used;³¹
- All patients who report no unprotected penetrative oral, vaginal or anal sex during this period should be asked the last time these events took place;
- All men should be asked if they have ever had sex with another man.

Rationale: to establish which STIs the patient may be at risk of, to offer relevant vaccinations and to inform partner notification.

3.4. Other components of the history

Previous STIs

Recommendation: all individuals should be asked about a history of STIs and HIV. IV C.

- The diagnosis and approximate date of diagnosis should be recorded.

All patients should be asked about a history of previous STIs (including HIV).

- Patients with a history of previous syphilis should have the date of diagnosis, stage of syphilis, treatment given and clinic of treatment recorded.³²

Rationale: to allow the interpretation of positive syphilis serology in patients with a previous history of syphilis.

- Past medical and surgical history.

Rationale: to identify conditions that may be associated with or influence the management of STIs.

- Drug history and history of allergies. All patients should have a history of current medication taken, including over-the counter remedies, and be asked for history of previous allergies, particularly to antibiotics.

Rationale: to identify medication that may interfere with sexual function, to identify potential drug interactions and if drugs cannot be given safely.

- Alcohol and recreational drug history. May be indicated particularly in cases where disinhibition may be

a factor in risk taking behaviour and in young people taking risk.³³⁻³⁹

Rationale: alcohol and recreational drugs are a major factor in sexual risk taking.³³⁻³⁶ Screening tools such as FAST and AUDIT³⁷⁻³⁹ are quick and simple to do. Some services will screen and undertake Alcohol Brief Interventions.

- For women born after 1995, a HPV vaccination history.

Rationale: to facilitate access to vaccination of those eligible if not started or not completed.

3.5. Contraceptive and reproductive health history

Increasingly, sexual health services are provided as integrated STI/contraception clinics. The contraception and reproductive health history may therefore vary according to whether the service primarily has an STI testing and treatment focus, or is providing an integrated service.

Recommendation: All women should be asked about the following: IV, C

- Contraceptive use and compliance
- Last menstrual period and menstrual pattern

Rationale:

- To identify pregnancy or pregnancy risk;
- To avoid drugs contraindicated in pregnancy;
- To provide post coital contraception if indicated;
- To give advice regarding contraception if necessary;
- To exclude contraceptive methods as a cause of irregular bleeding;
- To avoid prescribing enzyme inducing drugs in conjunction with low-dose hormonal contraceptive methods (except for injectables).

- Previous pregnancies including outcomes and complications

Rationale: part of the assessment of reproductive and sexual health, including any impact on the current presentation and the identification of children who may be affected by STIs.

- When the last cervical cytology was taken (if aged 25 years or over in England, Northern Ireland and Republic of Ireland or 20 years or over in

Scotland and Wales), the result and if ever abnormal (IV, C).

Rationale: to determine whether to recommend cervical cytology.

3.6. The integrated contraception and sexual health service

In the integrated contraception and sexual health service, the history will generally be more detailed in the following areas:

For female patients:

- Identify unmet contraceptive needs, including the need for emergency contraception and eligibility for different contraceptive methods. The UK Medical Eligibility Criteria for Contraceptive Use (UKMEC) shows areas that should be reviewed with regard to identifying risks associated with hormonal contraceptive methods.⁴⁰

Rationale: review of contraceptive need provides opportunities for information giving, motivational interviewing,⁴¹ and provision of contraception.

- Current contraceptive use, any difficulties with the current method, the correct use of, and satisfaction with the method used (including condoms and natural methods) and the need for on-going supplies.

Rationale: review of current contraception may provide opportunities to improve concordance and satisfaction, and unscheduled vaginal bleeding or pelvic pain may be a side-effect of contraception. The Faculty of Sexual and Reproductive Healthcare guidance deals with unscheduled vaginal bleeding in women using hormonal contraception, including points to cover in the clinical history, as well as management.⁴²

- Identifying any unintended pregnancy risk and the need for pregnancy testing

Rationale: recognising unwanted pregnancy allows for the provision of support and improves access to termination of pregnancy services.

- History of abnormal vaginal bleeding

Rationale: unusual vaginal bleeding may be due to cervical pathology and may prompt the offer of cervical examination and need for urgent colposcopy clinic referral.

- Menstrual pattern, including any change in pattern

Rationale: ascertaining the menstrual pattern is important for determining pregnancy risk, decision-making for EC provision, assessment of pelvic pain, and in supporting the diagnosis and referral of women with polycystic ovarian syndrome, other gynaecological disease and the post-menopause state where necessary.

- Mood change associated with the menstrual cycle

Rationale: provision of support and access to referral pathways for management of possible premenstrual syndromes.

- Family history

Rationale: to determine eligibility and contraindication for contraception according to UKMEC.⁴⁰

- Smoking history

Rationale: modifiable risk factor for cervical cancer and alters UKMEC status of combined hormonal contraception.

- HPV vaccination history

Rationale: To facilitate access to vaccination of those eligible if not started or not completed.

For male patients:

- Discussion with male patients about contraception, including contraceptive use by female partners

Rationale: provides opportunities for information giving, including male methods of contraception, motivational interviewing and may facilitate the use of services by female partners

- Identification of unrecognised lower urinary tract symptoms in men, particularly men aged >40 years. These include symptoms related to storage, voiding and post-micturition.

Rationale: recognition of these symptoms may aid in the assessment of other symptoms in men presenting to sexual health clinics. This may lead to detection of disease including diabetes mellitus, benign prostatic enlargement and prostatic cancer, and provide opportunities for information giving, support and access to referral pathways. The National Institute for Clinical Excellence (NICE) guidance provides the areas to cover in the clinical history as well as management.⁴³

Female and male patients:

- Identification of unmet need with regard to difficulties with sexual performance and satisfaction. Presentation related to psychosexual problems is common in women and men in sexual health settings.⁴⁴ In men, erectile dysfunction is associated with increased acquisition of STIs and non-use of condoms.⁴⁵

Rationale: provides opportunities for information giving, support and provision of referral pathways.

- Recognition of gender-based violence (GBV) or intimate partner violence (IPV). GBV/IPV is associated with sexual assault, STIs and unintended pregnancy as well as other risk factors.⁴⁶⁻⁵⁰

Rationale: provision of support and access to referral pathways. The Department of Health has produced a toolkit to help practitioners manage IPV.⁴⁷ NICE is producing Public Health guidance on preventing and reducing IPV.⁴⁹ Although there are no validated screening questions for IPV in sexual health settings, the brief questions in the pilot draft produced by the Camden Multi Agency Domestic Violence Forum are widely recommended for use.⁵⁰ Routine enquiry about current and historic gender-based violence aims to detect men and women who may be at risk of further ongoing violence and alerts practitioners to consider their safety. This is now mandatory in sexual health services in Scotland.³³

3.7. Risk assessment for blood-borne viruses

Recommendation: All individuals should be asked about the following (IV, C):

- Current or past history of history of injecting drug misuse; sharing of needles, syringes or other drug preparation and injecting equipment ('works'). To also include discussion of injecting drug misuse in sexual partners (IV, C).

Rationale: to identify the need for hepatitis B, hepatitis C and HIV testing and hepatitis B vaccination.^{20,51}

- Sex with a partner from or in a country with a high HIV prevalence.

Rationale: to identify sexual partners at higher risk of HIV (IV, C).

- HIV testing history.²⁰

Rationale: to determine whether HIV testing is necessary.

- Men should be asked if they have ever had sexual contact with another man and women asked about previous bisexual male partners.

Rationale: to identify the need for hepatitis B and HIV testing and hepatitis A and B vaccination.^{20,51}

- Hepatitis B risk (including patient's country of birth, sex with sex workers, partners from or in high prevalence countries, MSM and injecting drug users) and Hepatitis B vaccination history.⁵¹ (IV, C)

Rationale: identification requires serological testing of hepatitis B and vaccination

The following risks may be also asked about, where appropriate:

- Men and women may be asked whether they have ever exchanged money in return for sex (IV, C).

Rationale: to allow appropriate health promotion and hepatitis B testing and vaccination.²²

- Other risks: non-use of condoms associated with erectile dysfunction, repeated condom breakage or slippage, participation in group sex events, use of alcohol and non-injecting drug use, use of social networking websites to find sexual partners, use of high risk venues, receptive fisting, traumatic sexual practice and use of sex toys.

Rationale: to identify specific behaviours, associated with increased STI acquisition, that may provide opportunities for safer sex and substance use information-giving and support, and direct the offer of tests.

- Medical treatment/tattooing where sterility cannot be guaranteed.

Rationale: to establish the need to test for nosocomial blood borne virus acquisition.

3.8. Closing the sexual history

Recommendation: After the sexual history is completed, the clinician should (IV, C):

- Check with the patient that they have no other concerns that have not yet been discussed. These may include psychosocial concerns, issues about 'coming

out', safety in relationships, information about STI transmission.

- Explain the need for, and nature of, a clinical examination and tests.
- Give the patient the option of a chaperone for the examination.³⁷
- The method of communicating results to the patient should be agreed.

4. Documentation

4.1. General principles

Sexual health clinics have historically maintained their own record sets and record systems. That does not release them from following local and national guidance and law about records retention, data protection and subject access requests.⁵²⁻⁵⁴ Particular care is needed in sexual health services regarding the recording (and thus potential disclosure) of third-party information (where a person who is not the patient discloses something about the patient). Services that make use of general health records (e.g. as part of a hospital outpatient service or electronic system) need to consider who may access that record and ensure patients are informed about confidentiality arrangements.

Recommendation: It is recommended that (IV, C):

- *The record keeping of a sexual history should be in keeping with national standards of practice;*⁵⁴⁻⁵⁶
- *Services should agree minimum data sets taking into account local and national health priorities and reporting requirements. Services should audit record-keeping for completeness against this;*
- *Sexual health records should be processed and stored in accordance with local and national guidance and law. Third-party data should be clearly indicated.*

4.2. The use of standard history proformas

Many services record the sexual history on proformas with a locally agreed data set. These may:

- Assist timely record keeping;
- Make history taking more systematic;
- Reduce the chance of omitting important pieces of information;
- Facilitate audit.^{10,57}

Services should consider the range of data items in the light of their local and national health priorities and

needs. For example, in Scotland, routine enquiry about gender-based violence was mandated in sexual health services in 2008⁴⁸ and a national minimum data set for all sexual health services was agreed in October 2011 to replace the STISS coding system.⁵⁸

4.3. Electronic patient records

Many services now use clinical information systems. These range from simple demographic registers to full fledged bespoke sexual health paperless electronic record systems. Services implementing electronic record systems need to ensure that staff are trained in their use and are aware of their responsibilities for data protection. The DH/Royal College of GPs/BMA produced guidance for paperless working for GPs in 2011, with chapters on data accuracy and moving to paperless practice, including tips on how to consult while using a computer.⁵⁹ This is relevant to sexual health clinic settings. There are also several publications now that demonstrate the advantages of EPR in the sexual health setting.⁶⁰⁻⁶²

4.4. Computer-assisted interviews

Some services now offer computer-assisted self-interviews (CASI) or computer-assisted personal-interviews (CAPI) to replace some of the routine 'pen and paper' face-to-face clinical interview. Evidence shows a CASI approach to be acceptable in a sexual health setting with similar consultation times and few patients declining to answer risk questions.⁶³ Although CASI may yield additional disclosures in sensitive question areas, some evidence shows staff may not act on this information and that overall STI or HIV detection rates may not improve.⁶⁴

5. Specific circumstances

5.1. Seeing patients who are under the age of 16 years

There is a specific national guideline for children and young people.⁵¹ The following is a brief description of some of the important issues.

Competency

Recommendation: All patients less than 16 years of age should have their competency to consent to history taking, examination and treatment assessed and this assessment should be documented in the clinical notes.^{65,66} IV, C.

Safeguarding children

Where there are any concerns regarding a child's safety, there should always be serious consideration given to liaison with the local safeguarding children team.^{67,68}

Answers to the following additional questions may flag up the need for further assessment and liaison with the local safeguarding children team:

- Whether parents/carers are aware of the child's sexual activity;
- Whether parents/carers are aware of the child's attendance at the clinic;
- Whether the child has ever had non-consensual sexual contact;
- Age of sexual partner(s);
- Vulnerability (e.g. self-harm, psychiatric illness, drug or alcohol misuse, where there is an imbalance of power, e.g. youth workers/teachers, or grooming is likely).

Where children under the age of 13 years report sexual activity, this should be discussed with a senior colleague and there is an expectation that this will be discussed in confidence, with the local child protection lead. Reporting to social service and the police may be indicated but is not mandatory.⁶⁵⁻⁶⁹ In Scotland, the guidance is that 'practitioners should automatically share child protection concerns' for children who are having or have ever had sex when aged under 13.⁶⁸

5.2. Taking a sexual history in the outreach setting

Outreach clinics, either run by GUM clinics or which have been devolved to other providers, bring sexual health services out of traditional settings.

Recommendation: The following factors should be considered when taking a sexual history in an outreach clinic (IV, C):

- The structure of the sexual history taken should be adapted to the needs of the community or client group being served in order to be inclusive and to promote sexual well-being, regardless of culture, gender, age, sexuality and sexual lifestyle. For example, more focussed discussion of contraception in areas of high teenage pregnancy rates or the additional needs of MSM.¹⁰
- All services be provided in a comfortable environment that supports the patients' confidentiality and dignity.^{10,12}
- Specific consideration should be given to security measures for the protection of staff working in remote sites or in out-of-hours services.¹²

- Chaperoning for the medical interview and examination should be available and offered to all patients.¹⁰
- Clinical governance arrangements for outreach clinics should be robustly maintained for both NHS and non-NHS providers.
 - The use of a proforma for history-taking is recommended and its correct use should be audited regularly;
 - The scope of practice of the service should be clearly defined and referral pathways established for patients presenting with symptoms beyond this scope. For example: ectopic pregnancy; sexual assault; HIV post-exposure prophylaxis;
 - Information governance arrangements must be clearly defined, as the secure transfer of information is essential for good care. Protocols should be in place to guide the secure storage, transfer and relevant sharing of information.¹⁰ The use of an EPR is recommended as this is more secure and minimises the transfer of paper records.

6. Applicability

This guideline should apply to sexual history taking within GUM/sexual health settings. It is intended as a framework for sexual history taking and different settings will require the guideline to be adapted accordingly. It is likely that services in outreach settings and offering rapid access to screening will need to apply the components of this guideline appropriately to their level of service.

7. Resource implications

The resources required to meet the recommendations set out in this guideline will vary according to setting and level of service. It is acknowledged that to take a good sexual history often takes time and therefore has implications in the use of staff resources. However, the importance of obtaining the requisite information through a thorough sexual history is significant both to the individual and to the public health.

8. Auditable outcomes

1. Proportion of new/rebooked patients having a record relating to all six areas of the sexual history components in Section 3.3.1. Target 97%.
2. Proportion of new/rebooked patients having a record relating to all five of the required areas of the sexual history components in Section 3.7. Target 97%.

The 97% performance standards are to allow for one case in 40 (the number of cases suggested by the Royal College of Physicians⁷⁰) audited not having the recommended documentation owing to a random performance lapse not accounted for in a list of exceptions or exclusions, or a single data entry error.

Editorial independence

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Declarations of interest

None declared.

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Membership of the Clinical Effectiveness Group

From October 2012 the membership of the CEG is:

Dr Keith Radcliffe (Chair), Consultant Physician in Genitourinary Medicine, Whittall Street Clinic, Birmingham

Dr Mark FitzGerald, Consultant Physician in Genitourinary Medicine, Musgrove Park Hospital, Taunton

Dr Deepa Grover, Consultant in Genitourinary/HIV Medicine Barnet General Hospital/Royal Free Hospital

Dr Stephen Higgins, Consultant Physician in Genitourinary Medicine, North Manchester General Hospital, Manchester

Dr Margaret Kingston, Consultant Physician in Genitourinary Medicine, Manchester Centre for Sexual Health, Manchester

Dr Neil Lazaro, Associate Specialist in Genitourinary Medicine, Royal Preston Hospital, Preston

Dr Louise Melvin, Consultant in Sexual & Reproductive Health and FSRH representative, Sandyford, Glasgow

Dr Ann Sullivan, Consultant Physician in Genitourinary Medicine, Chelsea & Westminster Hospital NHS Foundation Trust, London

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