unity
Sexual Health

UNITY SEXUAL HEALTH SERVICES
REGISTRATION FORM

Please complete both sides (front & back) and return completed form to reception

Date:	Clinic Number
First Name (s):	Surname:
Date of Birth:	Country of Birth:

Gender: I consider myself to be	◯ Female (including Trans female) ◯ Non-binary	◯ Male (including Trans male) ◯ Other .....
What is the sex you were given at birth?	◯ Female	◯ Male

Address:	Contact Telephone Number Preferred Number: .....

We may need to contact you for appointment reminders and to talk to you about a test results. I understand that failure to supply these details may mean that Unity will not be able to contact me if I need treatment, in which case I take full responsibility for obtaining my results in person.

Please circle **all** ways which we can contact you: **If you don't indicate your preferred method of contact we will register it as a "Yes".**	Phone: Yes / No Text: Yes / No	Letter: Yes / No No contact: (circle if yes)
Is it OK to contact your GP? Yes / No GP Details:		

Confidentiality —What you need to know about your confidentiality at Unity Sexual Health
The only reason why we might have to consider contacting another service or professional (for example, your GP or Social Services) without your permission would be when we need to act to protect you or someone else from serious harm – and we would always try to discuss this with you first. If you have any worries about confidentiality, please feel free to ask a member of staff.

Important questions about your visit today

1. Have you been turned away from this clinic within the last week because the clinic was full? Yes / No
2. Were you seen within 48 hours of deciding to attend this clinic? Yes / No

SIGNATURE: ..... DATE: .....

University Hospitals Bristol, like all parts of the NHS, is required to collect information about our patients. It is used only for monitoring purposes, to ensure that our services reach everyone in the community.

I describe my ethnic origin as follows:

Asian or Asian British
- ☐ Bangladeshi
- ☐ Indian
- ☐ Pakistani
- ☐ Any other Asian background

Black or Black British
- ☐ African
- ☐ Caribbean
- ☐ Any other Black background

Mixed
- ☐ White & Asian
- ☐ White & Black African
- ☐ White & Black Caribbean
- ☐ Any other mixed background

White
- ☐ British
- ☐ Irish
- ☐ Any other White background

Other Ethnic Group
- ☐ Chinese
- ☐ Any other ethnic group

☐ I do not wish to disclose my ethnic origin

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The following questions are asked to help us care for you:

I have sex with: ☐ Females ☐ Males ☐ Both ☐ Non-binary / Other

Please tell us the reason(s) you are here today: (please tick all that apply)		
A	☐ I am 16 or under ☐ I am more than 28 weeks pregnant ☐ I am recently been paid for sex	☐ I have recently had sex against my will ☐ I have been sent by an outreach worker
	☐ I have had unprotected sex in the last 3 days with someone at high risk of HIV and might need PEPSE ☐ I have had unprotected sex since my last period and may need emergency contraception ☐ I have been sent with a letter from another doctor/nurse (please give to reception)	
B	☐ I just want a check-up and tests for Sexual Transmitted Infections (I do not have symptoms and I do not need to discuss contraception)	
C	☐ I have tested positive for an infection and need treatment ☐ I would like to discuss my contraceptive choices or a supply or pills / injection ☐ I would like to have a coil or implant inserted or changed ☐ I would like to talk to someone ☐ I have had sex with someone that has or may have an infection. Please include the infection if known:	
D	**I have the following symptoms:** ☐ Pain when peeing ☐ Irritation or tingling	☐ Discharge
E	☐ Lumps, bumps or rash	☐ Pain—Stomach ache / Testicles / Other
	☐ Other:	

Your wellbeing: (please circle)				
Do you feel scared of your partner (of your ex) or have they ever tried to hurt you?			Yes	No
Would you describe yourself as a:		Smoker	Ex-smoker	Non-smoker
Do you use any party / club / recreational drugs?	Yes	No		
If yes do you:	Inject	Snort	Smoke	Take pills
If yes, do you use recreational drugs / chems to heighten the sexual experience?	Yes	No		
				Score
How often do you have a drink containing alcohol?	Never Monthly or less 2-4 times a month 2-3 times per week 4+ times per week			0 1 2 3 4
How many units of alcohol do you drink on a typical day when you are drinking?	1-2 3-4 5-6 7-9 10+			0 1 2 3 4
How often have you had 8 or more units on a single occasion in the last year?	Never Less than monthly Monthly Weekly Daily or almost daily			0 1 2 3 4
Score:	A score of **5 or more** indicated increasing or higher risk drinking.			