

## Taking a Sexual History in Genitourinary Medicine

### 1. Introduction

There are two main categories of sexual history taking:

- 1) A risk assessment of acquisition of a sexually transmitted infection
- 2) An assessment of sexual dysfunction.

There are no hard and fast rules about taking a sexual history, however it can be helpful to have a schema to fall back on. The schema outlined here is appropriate for risk assessment, but many questions are applicable to those with sexual dysfunction.

#### **Rationale for Sexual History**

Taking a Sexual history is necessary in order to inform your medical management, so **do not apologise** to the patient, but be prepared to explain why.

1. To identify need for screening for infection
2. To assess risk of patient's acquisition of infection.
3. To assess risk of transmission of infection.
4. To assess risk of pregnancy.
5. To educate about the patient's sexual health.
6. To identify which clinical specimens need to be obtained

### 2. Basic Communication Skills

The Sexual history is a sensitive area so Basic Communication Skills are even more important than usual.

- Privacy is important
- Introduce yourself.
- Be aware of body language.

Many patients do not wish to meet your eye directly when discussing sexual matters, so respect this, but give plenty of opportunity for brief eye contact or a nod of encouragement. Make use of silence to give the patient time to disclose things which they may never have discussed before.

- If a patient is distressed (angry / embarrassed / anxious) it can be useful to acknowledge this

“ I can see that this is uncomfortable for you...”

**Language** – ensure that the patient *understands* the questions. Remember cultural differences may cause difficulty and confusion in communication. Consider the use of interpreters. Use *simple, clear language*. Basic anatomical terms are OK for most patients but make sure it is clear to you both what is being discussed. E.g. use ‘vagina’, rather than ‘down below’

Ask for the information you need e.g. "Did you use a condom?" not "Did you use protection?"

Colloquialisms are fine if introduced by the patient but beware of introducing them yourself. E.g. 'fanny' has many meanings (see appendix).

Patients may be flippant - often to disguise nervousness. It is not good practise to be flippant in response as it can easily backfire. Smile, but try to steer the patient back to a basic account of the problem.

**Summarising parts of the history back to the patient can be helpful.**

"So, it was about two weeks after you split up with your regular partner that you had sex with this other partner, and about a week later that you noticed the discharge...."

### **3. The Sexual History**

#### **3.1 Introduction**

It is useful to start with an *open question* such as:

- "How can I help?" This invites the patient to tell you their problem in their own words.
- Acknowledge the patients request but say that you need to ask a few questions first.

**E.g. "Of course I can give you emergency contraception but I just need to ask a few questions first to make sure you need it."**

Give *time* for the patient to explain things properly.

*Silence* can be useful. A minute spent just nodding, prompting and reflecting words and phrases will often reveal the problem in its entirety.

- *Reflection* is a particularly useful tool:  
Patient : " I just feel dirty".  
Doctor: " Dirty.....?"  
Patient : " Like I might have caught something"  
Doctor : " Something like...?"  
Patient : " Well I don't know, like AIDs or something.."
- However if the patient is very anxious silence may be experienced in a persecutory way and it is more helpful to assist the patient to articulate what the problem is by asking closed questions, which articulate the problem. "Do you have a discharge? Does it hurt when you have sex?" "Did you have anal sex?"
- Ask about details of the presenting problem:
- Ask about the timescale of the problem.
- If the problem is recent and the patient has not mentioned any triggers:

"Did anything happen at the start of this problem which you thought may have caused it"

- If the problem is longstanding:

“What made you come to see us just now - have things got worse, or changed?”

- In addition, “Have you had any thoughts yourself about what might be going on?”

### 3.2 Sexual Partners

- Patients will often tell you all you need to know without asking, if not ask specifically:
  - Use the term ‘partner’, instead of girl / boyfriend or wife /husband etc..
  - Don’t assume that all partners will be of the same gender.
  - Beware assumptions.
  - Asking, “ Are you married?”, or something similar, assumes monogamous heterosexuality which can make it difficult for some patients to discuss their sexual health. Doctors may be seen to be judgemental and heterosexist and one must avoid reinforcing such notions.
  - Beware assumptions about names e.g. Chris, Terry, Sam etc.
  - “Do you have a sexual partner (at the moment/ just now)?” or “ When did you last have sex?”
  - “Is (was) that a casual partner or a regular partner?”
  - “How long have you been with that partner?”
  - “Is your partner male or female?” (or “is that a male partner? or “is that a female partner” if you feel you don’t want to hedge your bets)
- If you have put the patient at ease, you may well get all of these details without asking specifically.

#### Other Partners

- It is important to establish if there have been other partners.
- We recommend the question “ When did you last have a partner other than that one?”

It covers all eventualities without implying any assumptions.

- Then establish the gender of the other partner, type of sexual activity, condom use, country (see travel below) .
- The number of partners in the past three months gives an indicator of risk of infection.
- The number of lifetime partners may occasionally be relevant.
- If there are many partners, you could simply ask “how many others in the last three months”. **You may have to ascertain further risk by repeating the risk assessment**

### 3.3 Sexual activities

It may be relevant to ask about specific sexual acts. For example:

- **Oral sex**- herpes virus, hepatitis B and gonorrhoea can be transmitted oro- genitally. Primary genital herpes can occur in those who have never had penetrative sex.
- **Oral –anal** -sexual contact (rimming) may transmit gastro-intestinal pathogens such as *Giardia intestinalis* in men who have sex with men.
- **Anal sex** -is a specific risk factor for HIV in men who have sex with men, as well as in heterosexual women (of whom 5-20% disclose anal sexual activity in studies).
- **Sex toys** such as vibrators may need to be asked about.

### 3.4 Sexual Practises

#### Male to male

- Establish what sort of sex. Is it mutual masturbation or oral sex only? If oral, is it receptive or active. (Who does what to whom?) Do they ejaculate?
- One needs to ask do they have anal intercourse and if so what sort.
- “Are you active or passive (give - or receive)?” e.g. “did you have anal sex? “Do you have receptive anal sex or do you penetrate (put your penis in him)?”
- Establish condom use.

#### Woman to man

- Beware of the assumption that heterosexual sex always means vaginal penetration - it can of course mean other forms of sexual activity such as:
- Oral sex, intra-crural, mutual masturbation, anal sex.
- Sometimes it is necessary to establish exactly what is happening.

#### Woman to woman

- Beware of the assumption that this is only oral sex. It might be necessary (for instance in the lesbian woman who has IMB) to establish whether there has been penetration, the use of sex toys, perhaps of fisting, fingering.

#### Sex Toys

- It may be relevant to ask about sex toys, e.g.
  - Whether vibrators have been used,
  - Whether condoms were used with vibrators
  - And whether they are washed and cleaned in between use.

#### Fetishes

- These can cover a wide range of behaviour some of which include the use of fetish objects such as rubber, shoes etc. These are unusual, and certainly not part of a routine sexual history, but patients might occasionally want to ask about risk of infection in relation to these practices e.g. sadomasochistic practices where there is a risk of drawing blood (see glossary).

### 3.5 Condom use and contraception

Different individuals interpret the word 'contraception' in different ways - some take it to mean condoms only. It is worth asking specifically about condoms and about the oral contraceptive, coil, vasectomy and so on, as well. Asking about the use of barrier protection, can be difficult and its use may vary e.g. penetration may occur prior to use. (Beware the pre-ejaculate.)

- Sex workers use condoms with clients but may not with partners.
- Condoms may be used for vaginal but not oral sex.
- If you ask "Did you use a condom?" , most people will say "Yes".  
Asking " Do you ever use condoms"  
Or  
" Did you use condoms with any of those partners?"  
Followed by " Just sometimes, mostly or always?"  
May be more likely to elicit an honest answer.  
Asking, " When did you last have sex without a condom?" is even better.

### 3.6 Travel

It is important to ask in which part of the world sex took place and often to ask the nationality of sexual contacts. Don't assume that sex abroad will have been with a partner of local origin.

### Summary

The above notes help to guide sexual history taking. Each health care professional will develop with time a set of questions which best suits them for taking a sexual history. This is a sensitive area and basic communication skills are even more important than usual. It is essential to be non-judgemental and to avoid making assumptions. It is useful to start with an *open question* such as: "How can I help?" This invites the patient to tell you their problem in their own words. However often patients are embarrassed/anxious and in order to obtain the relevant information closed questions are required.

As stated, there is no right or wrong way but you must feel comfortable with the questions you ask. The following is a suggested basic set of questions which can be modified according to the situation and to the individual clinician's own style. In general it usually most appropriate to ask the questions in chronological order i.e. immediate then recent then historic.

When did you last have any kind of sex at all?  
Was that a partner you see regularly or a one off?  
If regular – How long have you been together?  
If one off – Do you know that person at all? (a “known casual” encounter ie. You know the person but don’t usually have sex with them as opposed to never met before)  
If no clues thus far – was that a male or a female partner?  
What kind of sex did you have? If not forthcoming ask directly (as appropriate to gender of partner) Oral? Vaginal? Anal? Mutual masturbation?  
Was that without a condom?  
Or for more regular partner - Do you use condoms never, sometimes or always?  
Is your partner local as well? Where does your partner come from?  
What part of the world were you in? (particularly if casual – holiday romance?)

When did you last have any kind of sex with someone different?  
Then repeat all above

And continue.....! Aim to take a sexual history going back over last 3-6 months.

Sometimes you may need to say something like - Roughly how many partners do you think you’ve had in the last 3 months? And you may need to give options - 5? 10? 50?

## **Conclusion**

Sexual history taking is an integral part of risk evaluation and, like any other skill; it needs to be practised in order to be used effectively.