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2019 UK National Guideline for consultations requiring sexual history taking: Clinical Effectiveness Group British Association for Sexual Health and HIV

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Abstract

This guideline is an update of a previous version published in 2013. In this new version, we have reflected changes in the way sexual health services are now provided by assuming an integrated Sexual Health/Sexual and Reproductive Healthcare service. There are new recommendations for online testing, female genital mutilation (FGM), chemsex and considerations for transgender (and non-binary) individuals. Previous versions rather assumed a cis-gender clientele and so we have taken a more mechanistic approach to sex and risk without assuming gender identification. We have updated our gender terminology in line with the British Association for Sexual Health and HIV 'sexual health standards for trans, including non-binary, people' although have retained the terminology of 'men' and 'women' in a few cases where it related to other guidelines, e.g. human papillomavirus vaccination and FGM.

Keywords

Women, sex workers, sexual behaviour, men, environment

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New in the 2019 Guidelines

This guideline is an update of a previous version published in 2013. In this new version, we have reflected changes in the way sexual health services are now provided by assuming an integrated Sexual Health/Sexual and Reproductive Healthcare (SH/SRH) service. There are new recommendations for online testing, female genital mutilation (FGM), chemsex and considerations for transgender (and non-binary) individuals. Previous versions rather assumed a cis-gender clientele and so we have taken a more mechanistic approach to sex and risk without assuming gender identification. We have updated our gender terminology in line with the British Association for Sexual Health and HIV (BASHH) '*sexual health standards for trans, including non-binary, people*' https://www.bashh.org/media/4400/bashh-recommendations-for-integrated-sexual-health-services-for-trans-including-non-binary-people-2019pdf.pdf although

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have retained the terminology of 'men' and 'women' in a few cases where it related to other guidelines, e.g. human papillomavirus vaccination and FGM.

Introduction and methodology

This guideline is an update of the guideline published in 2013 and, like its predecessor, provides guidance for best practice in consultations requiring sexual history taking. It is primarily intended for use in UK SH/SRH settings, but can be applied or adapted for use in other settings where sexual health assessments are undertaken. This guideline is for use by all health care professionals delivering SH/SRH care to patients and for use when dealing with patients who are attending with symptoms that may be attributed SH/SRH issues, are requesting screening for sexually transmitted infections (STIs) or wish to discuss contraception issues. 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.

Objectives

The purpose of the guideline is to help improve the sexual health of individuals attending SH/SRH clinics by encouraging high standards of sexual risk assessment. The guideline offers recommendations on best practice regarding sexual history irrespective of gender, 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 UK clinic settings, evidence is sometimes cited from non-UK sexual health settings and from other settings outside sexual health care where necessary.

Search strategy

The British Association for Sexual Health and HIV:2015 framework for guideline development and assessment (https://www.bashhguidelines.org/media/1176/2015-guidelines-framework_updated-may-2018.pdf) was used to develop these guidelines. In short, a literature search was undertaken using the terms 'sexual history', 'sexual history-taking' and 'sexual risk assessment' on Medline and PubMed databases from July 2013 to February 2019. In addition, sections on sexual history taking in relevant BASHH and other guidelines were reviewed for other references. Forward and backward searching from key references was also conducted.

Methodology for writing and grading the evidence

Evidence was graded using BASHH version of the GRADE system (Appendix 1). Sections of the guidelines were divided between small groups of authors who critically appraised the data using a hierarchy of evidence as outlined in the GRADE appraisal system (best evidence first: meta-analysis, systematic reviews, randomised controlled trials, other studies, case reports, expert opinion). Recommendations were then made by consensus of the sub-groups and then the full writing group.

Equality impact assessment

An equality impact assessment was undertaken and is published on the BASHH website.

Piloting and feedback

The Writing Committee includes Genitourinary Medicine clinicians and representatives from the Faculty of Sexual and Reproductive Healthcare (FSRH), nursing and Sexual Health advising. Prior to publication, the guideline was appraised using AGREE II by CEG, and then will be placed on the BASHH website for a two-month consultation period inviting all BASHH members to submit comments to the CEG. Copies will be circulated to the Genitourinary Nurses Association, the Society of Sexual Health Advisers chairs and the FSRH for comment and peer review. It will also reviewed by the BASHH Public Panel. This guideline will be piloted before it is finally ratified.

Guideline update

This guideline will be updated no later than five years after publication

Contents

A. KEY RECOMMENDATIONS

Confidentiality and Clinic Environment (Section 1)

- Sexual history taking should take place in a confidential, private environment (1, D)
- All clinics should have a confidentiality policy that should be displayed in the waiting area or otherwise made available to patients. (1, D)
- Specific consideration should be given to the confidentiality of information on gender identity for transgender and non-binary patients. (1, D)
- All patients should be offered a chaperone for any intimate examination in accordance with GMC guidance (1, D)
- All patients should be offered a clinician of their preferred gender where possible (1, D)
- The utmost care should be taken to preserve the confidentiality of patients and their sexual contacts during the consultation. (1, D)

Communication (Section 2)

- Clinic literature/advertising leaflets should include sections regarding the need to take an appropriate sexual history and ask questions of a sensitive nature. (1, D)
- The ability to communicate effectively is required of all clinicians and may be important in improving health outcomes (1, D)
- Assessment of clinician communication skills should form part of the assessment of service quality. (1, D)
- All sexual health clinics should have policies in place to address the needs of patients with whom there may be communication challenges, including those with literacy problems (1, D)

Components of a contraception and sexual history (Section 3)

- Key components of the sexual history will include (1, D):
  - Reasons for attendance,
  - STI risk, including partner details
  - Presence or absence of symptoms,
  - Contraception use and risk of pregnancy,
  - Other sexual health related issues,
  - HIV/viral hepatitis risk,
  - Risk behaviours,
  - Safeguarding concerns including Intimate Partner Violence and FGM
  - Use of recreational drugs (including alcohol and chemsex).

- If a symptom review is performed, the components will include (1, D):
  - Dysuria,
  - Genital skin problems,
  - Unusual vaginal discharge,
  - Unusual or a change in vaginal bleeding, including post-coital and inter-menstrual bleeding,
  - Urethral discharge,
  - Abdominal pain/deep dyspareunia,
  - Testicular discomfort or swelling,
  - Peri-anal/anal symptoms

- All individuals should be asked about their last sexual contact (LSC) and previous sexual contacts (PSC) with a different partner(s), if within the last three months. This should include (1, D):
  - The time interval since the last sexual contact (LSC) and previous sexual contact (PSC),
  - The gender of partner(s),
  - The partnership type (steady committed, new relationship, occasional, one off) and whether the partner is contactable,

- The type of sexual contact/sites of exposure (for example, oral, vaginal, anal, rimming, fisting, use of sex toys) (1, A).
- Condom use/barrier use (and whether properly used).
- Any symptoms or any risk factors for blood-borne viruses in the partner, for example known or suspected STIs, injecting drug use, previous sex with men (for male partners) and any other risk of sexual infection.

Other components of the history

- The following should be covered as part of a comprehensive history (1, D):
  - Past medical and surgical history where relevant (specifically obstetrics and gynaecology)
  - HPV vaccination history in women born after 1995, men born after 2005 and MSM between the ages of 20 and 45 years[i]
  - Identification of unmet need about difficulties with sexual performance and satisfaction
  - Drug history and history of allergies
    For all patients with a uterus:
  - Participation in the National Cervical Screening Programme
  - Family history to determine eligibility and contraindication for contraception according to UKMEC.
  - Smoking history for (UKMEC) status for some contraceptives
  - Pregnancy risk should include assessment of transgender men and non-binary (assigned female at birth) people, if they have not undergone hysterectomy or bilateral oophorectomy, who are having vaginal sex with a risk of pregnancy and do not wish to conceive

Record keeping (Section 4)

- The record keeping of a sexual history should be in keeping with national standards of practice (1, D)
- 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 (1, D)
- Sexual health records should be processed and stored in accordance with local and national guidance and law. Third-party data should be clearly indicated. (1, D)
- Electronic Patient Records, Standard History Proformas and Computer Assisted Interviews should be strongly considered to aid efficiency. (1, B)

Specific Circumstances (Section 5)

Seeing patients who are under the age of 16 years (Section 5.1)

- 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. (1, D)
- 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. (1, D)

Taking a sexual history in the outreach setting (Section 5.2)

- The following factors should be considered when taking a sexual history in an outreach clinic (1, D):
  - The structure of the sexual history taken should be adapted to the needs of the community or client group being served
  - All services be provided in a comfortable environment that supports the patients' confidentiality and dignity.
  - Specific consideration should be given to security measures for the protection of staff working in remote sites or in out-of-hours services
  - Chaperoning for the medical interview and examination should be available and offered to all patients.
  - 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. The use of an electronic patient record is recommended as this is more secure and minimises the transfer of paper records

Patients identified with Female Genital Mutilation (FGM) (Section 5.3)

- Enquiring about whether FGM has been previously performed should be routine for all consultations

with cis-gender women and patients assigned as female at birth (1, C).
- When FGM is identified to have taken place, a standard FGM consultation template should be used which collects the following information (1, C):
  - Type of FGM (grade 1–4) and any complications of the procedure
  - Age when performed
  - Where performed
  - Has it been reported to police/social services if girl is under 18?
  - Any other family members with FGM
  - Any children in the family at risk of FGM
  - Woman's knowledge of the law on FGM and attitudes to the practice
  - Family's attitude to FGM
  - Knowledge of support services and access to surgical reversal.

Consultation skills when not 'face-to-face' (section 5.4)

- Providers should be aware there are obstacles to consulting via remote means.
- There are also difficulties in assessing service users with vulnerabilities; such as young age, people with mental health problems, adults who lack capacity, those with complex medical histories, polypharmacy, or where there may be a need to break bad news or complex ethical issues.
- It is recommended that in these or other circumstances where a concern may be raised, a user should be sign-posted into the local SH/SRH service for a face-to-face consultation (2, D).

B. EVIDENCE

1. Confidentiality

1.1 General medical confidentiality. The Common law duty of confidentiality applies to information given in circumstances where it would be expected that there is a duty of confidence. In practice, this requires that any information recorded on print or electronic media, or remembered, must not be disclosed, regardless of age, mental or physical health, and whether or not contact is continued with the information giver, except under specific conditions (*vide infra*). The NHS Care Record Guarantee[1] assures patients regarding the use of their information. As well as this, there are specific written legal requirements for confidentiality, including employment contractual obligations[2–4] and a range of statutory legislation governing the handling of healthcare information. The General Data Protection Regulation (GDPR)[5,6] is a European Union-wide regulation, aimed at updating data protection in the era of the Internet, that came into force in the UK on 25 May 2018, repealing the Data Protection Act (1998). The GDPR, together with the new Data Protection Act 2018 (DPA 2018),[7] is the mainstay of data protection in the UK. GDPR requires clinics to provide patients with an information leaflet (or electronic transmission of information) about how their data are used and shared. A personal data breach includes not only deliberate or accidental unauthorised disclosure, loss or theft, but also unauthorised alteration or loss of access to personal data (e.g. owing to a cyberattack). The GDPR also provides for rights to data access, rectification, erasure, restriction, portability and objection to processing including profiling. The DPA 2018 brings the GDPR into domestic law in preparation for the UK leaving the European Union, and implements the UK derogations from the GDPR.

The United Kingdom (UK) General Medical Council (GMC) guidance on confidentiality has been updated with regard to this recent legislation,[8] and includes specific guidance on disclosing information with regard to serious communicable diseases and needlestick injury. The UK Nursing and Midwifery Council Code also includes confidentiality.[9] The duty of confidence may be broken where this is justified to be in the interest of the patient or the public, legally required (either under statute or a court order) or where patient consent has been obtained to do so. Confidence should only be broken with the agreement of a service's Caldicott Guardian, with adherence to NHS[10,11] and Caldicott guidance,[12] and may also involve senior colleagues, an organisation's legal service and a medical defence agency. Examples of where the public interest can be a defence include breaking the confidentiality of a patient who refuses to inform a sexual partner of a harmful sexually transmissible infection, and sharing confidential information with social services where there is a risk of harm to a child. Any decision to disclose information about an individual lacking capacity should be in accordance with NHS guidance[13] and organisational policy. The legal requirement of disclosure includes the notification of the suspicion or detection of certain infections or diseases to public health authorities. Lists of these differ between the devolved UK governments, and include conditions that may be detected in a clinic managing STIs, including acute infectious hepatitis, infectious bloody diarrhoea, invasive group A streptococcal disease and tuberculosis. When confidence is to be broken, where appropriate, the patient should be informed of this, and supported, by STI clinic staff, and before contact is made by another agency.

Patient-related information, in various forms may be handled by healthcare workers using a variety of electronic media, and may be communicated via

emailed messages or texting. Data encryption e-mail services must be used by both the sender and recipient if patient details are communicated in this manner to prevent unauthorised interception of messages. NHS mail is the only NHS e-mail service provider that securely transmits messages and is endorsed by the government.[2] Confidential patient information on any electronic device must also be encrypted since password protection can be easily bypassed. The GMC supports communicating with patients in a format that suits them and emailing patients is permissible,[14] provided the risks of using unencrypted email have been explained, patient consent obtained and the information is not person-identifiable or confidential information. Texted messages may be copied to an email account. Keeping any patient information isolated from the patient record is not consistent with current data protection legislation and guidance and, in the absence of any specific guidance, consideration should be given to transferring such information, with reference to original versions where appropriate, or an appropriate summary, in the patient record, and any duplicate record deleted.

1.2 The sexual health clinic and confidentiality. Recent legislation provides assurances of data protection and security in sexual health services. This includes the GDPR data protection impact assessment processes[6] that could be likened to the duty of enforcement of confidentiality originating from Public Health (Venereal Diseases) Regulations 1916,[15] and most recently updated in NHS Trusts and Primary Care Trusts (Sexually Transmitted Diseases) Directions 2000[16] (applicable only in England). The Directions allowed specific circumstances for disclosure of identifying information: for the purpose of treatment of STIs or for prevention of infection. However, the Directions are subject to amendments of the National Health Service Act 2006[17] by the Health and Social Care Act 2012,[18] such that the names of the health service organisations to which the Directions apply/ied – NHS Trusts and Primary Care Trusts that already ceased to exist in 2013 – are being omitted in an ongoing legislative editorial process.[19]

Hence, the Directions apply only to remaining English NHS Hospital Trusts, and not to NHS Foundation Trusts or other services providing STI management services, and therefore are no longer applicable to most STI management services.

In practice, UK sexual health clinic staff do not inform other health care workers of a patient's attendance, unless the patient has been referred by letter or consents to such communication. It is good practice to seek consent to inform other appropriate health service providers of diagnoses or procedures that may have longer term health implications (e.g. HIV infection, syphilis, pelvic infection, sterilisation procedures). Cervical cytology may be provided in sexual health clinics, as part of a national cervical screening programme, and consent obtained to use personal information that results may be shared with the programme and colposcopy and primary care services. If it is in the patient's interest for another health service provider to be informed, consent for disclosure should be recorded. Secure digital systems should also be used 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 disclosure has been obtained.

Specific consideration should be given to the confidentiality of information on gender identity for transgender and non-binary patients. The knowledge that a patient is transgender is considered to be 'protected information' under the Gender Recognition Act (2004).[20] Section 22 of the act and its associated statutory instrument (Statutory Instrument No. 635, 2005)[21] specifies that disclosure of this information should only occur under the following circumstances: disclosure is made to a health professional, the disclosure is made for medical purposes and the person making the disclosure reasonably believes that the subject has given consent to the disclosure or cannot consent.

If it is important that gender identity information be communicated to another health care professional, it is good practice to seek and document explicit consent. It should not be assumed that consent to disclose other aspects of a patient's medical history includes disclosure of gender identity. Further information can be found in the BASHH recommendations for integrated sexual health services for transgender individuals (In preparation).

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.[22,23] 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 sound-proofed room.[24]
- 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.[23] However, the patient should be offered a chaperone for any intimate examination.[22,25,26]
- 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 (1, D)
Recommendation: All clinics should have a confidentiality policy that should be displayed in the waiting area or otherwise made available to patients. (1, D)
Recommendation: All patients should be offered a chaperone for any intimate examination in accordance with GMC guidance (1, D)
Recommendation: All patients should be offered a clinician of their preferred gender where possible (1, D)

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.[27] 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 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 SH/SRH 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 include asking questions on drug and alcohol use, domestic violence and unwanted sexual attention. 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 and ask questions of a sensitive nature. (1, D)

2.2 Communication skills. The ability to communicate effectively is required of all clinicians and may be important in improving health outcomes.[28,29] 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[ii] followed by exploration of initial concerns and more closed questions as the consultation continues.[28]
- Explaining the rationale for some of the questions asked.
- Consider 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.[30] Clinicians should be aware of maintaining a non-judgemental approach to discussion including contraception and termination of pregnancy. Questions about alcohol and drug use, domestic violence and unwanted sexual attention are now a routine part of taking a sexual history. Clinicians should ensure they have had relevant training to be able to ask and respond to these questions in an appropriate manner.

Although there are well-recognised models of best practice in communication skills training, assessment of the quality of communication skills is complex.[31,32] A variety of different mechanisms for assessing communication skills have been proposed including patient questionnaires or Patient Reported Experience Measures (PREM), direct or video-recorded consultation with patients or actors or peer appraisal.
Recommendation: Assessment of clinician communication skills should form part of the assessment of service quality. (1, D)

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 may be communication challenges, including those with literacy problems (1, D)

3. Components of a contraception and sexual history

The appropriate detail of the contraception and sexual history will vary depending on the reason for presentation and type of consultation available (i.e. nurse, doctor or health care assistant led) but should allow for an assessment of:

- STI risk
- Symptoms to guide the examination and testing
- Contraception use and risk of pregnancy
- Other sexual health related issues (also allowing for a discussion of psychosexual problems)
- HIV, viral hepatitis risk for both testing and prevention
- Risk behaviours, which will then facilitate health promotion activity including partner notification and sexual health promotion
- Safeguarding concerns such as domestic violence to facilitate appropriate referral. The use of screening tools when available is recommended, i.e. Spotting the Signs for Child Sexual Exploitation.
- Use of recreational drugs (including alcohol and chemsex) to facilitate appropriate referral.

A summary of suggested sexual histories in different testing scenarios is given in Tables 1 to 3.

3.1 Reasons for attendance. It can be helpful to start the sexual history with less intrusive questions regarding presenting concerns and symptoms before asking questions that are more sensitive. After the reason for attendance has been identified, the health professional should ask closed questions to identify specific symptomology. 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.

Health professionals should check with the patient if there are any other concerns that were not identified during the initial discussion. These may include psychosocial and psychosexual concerns, issues surrounding safety in relationships, and requests for general information about sexual and reproductive health and wellbeing.

3.2 Symptom review. It is uncertain whether a symptom review in patients not reporting symptoms is useful. Many health professionals ask about specific genital symptoms in case this reveals overlooked or ignored problems. All health professionals should ask further questions regarding the duration and nature of any reported symptoms.[22,23]

Recommendation: We recommend routinely asking about the following symptoms that may indicate underlying pathology: (1, D)

- Dysuria
- Genital skin problems
- Unusual vaginal discharge
- Unusual or a change in vaginal bleeding, including post-coital and inter-menstrual bleeding
- Urethral discharge
- Abdominal pain/deep dyspareunia
- Testicular discomfort or swelling
- Peri-anal/anal symptoms

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 results of the STI testing are positive. For example, this may be appropriate in a minimal-contact health care assistant-led clinic or remote and online testing services.

Using 'bridging' questions, which link general lifestyle questions to sexual history questions or 'universal' questions (questions which are explicitly asked of all patients), may help when introducing sensitive questions.[33] 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.[34]

It is important to ascertain the type of sexual contact/sites of exposure among individuals attending services in order to be able to identify which sites need to be sampled.[35]

Table 1. Sexual health history.

	History domain	History item
All patients		
	3.1 Reason(s) for attendance	Establish reason(s) for attendance
	3.2 Symptoms	Symptoms review
		Duration of symptoms
	3.3 Sexual history	Time since last sexual contact (LSC)
		Time since previous sexual contact (PSC) (if within the last three months)
		Number of sexual partners in last 3 months
		The gender of partner(s)
		The partnership type and whether the partner can be contacted
		The type of sexual contact/sites of exposure
		Condom use/barrier use
		Any symptoms or any risk factors for blood-borne viruses in the partner
	3.4 Other components	The diagnosis of previous STIs and the approximate date of diagnosis
		Past medical and surgical history
		HPV vaccination history
		Family history
		Drug history and history of allergies
		Alcohol and recreational drug history
		Smoking history
		Identification of unmet need with regard to difficulties with sexual performance and satisfaction
		Recognition of gender-based violence (GBV) or intimate partner violence (IPV)
		History of female genital mutation (FGM)
Individuals with a where there is the potential for pregnancy		
		Discuss pregnancy planning, contraceptive use, and unmet needs
		History of unusual or altered vaginal bleeding
		Obstetric history, including outcomes and complications
		Assessment of other symptomatology such as pelvic pain, dysmenorrhoea or menorrhagia

HPV: human papillomavirus; STI: sexually transmitted infection.

Table 2. Minimum sexual history for asymptomatic patients requesting a STI screen.

- Confirm lack of symptoms
- Establish competency, safeguarding children/vulnerable adults
- Date of last sexual contact (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
- Last menstrual period (LMP), contraceptive and cervical cytology history where indicated[a]
- Blood borne virus risk assessment and vaccination history for those at risk
- Recognition of gender-based violence/intimate partner violence
- Alcohol and recreational drug history
- Agree the method of giving results

STI: sexually transmitted infection.
[a]Individuals where there is the potential for pregnancy (including trans men and non-binary [assigned female]) people, who are having vaginal sex with a risk of pregnancy and do not wish to conceive.

3.3.1 Information about previous sexual partners. *Recommendation: All individuals should be asked about their last sexual contact (LSC) and previous sexual contacts (PSC) with a different partner(s), if within the last three months. (*1, D*)*

- The time interval since the last sexual contact (LSC) and previous sexual contact (PSC).
  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.
- The gender of partner(s).
  Rationale: to inform STI risk, to establish eligibility for hepatitis screening and vaccination and HPV

Table 3. Minimum sexual history for symptomatic patient requesting a STI screen.

- Symptoms/reason for attendance
- Establish competency, safeguarding children/vulnerable adults
- Date of last sexual contact (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[a] and cervical cytology history where indicated where indicated
- Pregnancy and gynaecological history where indicated
- Blood borne virus risk assessment and vaccination history for those at risk
- Recognition of gender-based violence/intimate partner violence
- Alcohol and recreational drug history
- Past medical and surgical history
- Medication history and history of drug allergies
- Agree the method of giving results

STI: sexually transmitted infection.
[a]Individuals where there is the potential for pregnancy (including trans men and non-binary [assigned female]) people, who are having vaginal sex with a risk of pregnancy and do not wish to conceive.

vaccination, to inform the offer of other relevant prevention options (for example, HIV PEP and PrEP) and to inform partner notification.

- The partnership type (steady committed, new relationship, occasional, one off) and whether the partner can be contacted.
  Rationale: to facilitate partner notification.
- The type of sexual contact/sites of exposure (for example, oral, vaginal, anal, rimming, fisting, use of sex toys) (1, 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 to inform discussions about other appropriate HIV prevention options.
- Any symptoms or any risk factors for blood-borne viruses in the partner, for example known or suspected STIs, injecting drug use, previous sex with cis- or transgender men (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 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.[36] 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.[37] 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.
- All patients who report no condom-less oral, vaginal or anal sex during this period should be asked the last time condom-less sex took place.

3.4 Other components of the history. Recommendation: As part of a comprehensive history, patients should be asked about the following: (1, D)

- The diagnosis of previous STIs and the approximate date of diagnosis and treatment.
  Patients with a history of previous syphilis should have the date of diagnosis, stage of syphilis, treatment given and clinic of treatment recorded.[38]
  Rationale: to allow the interpretation of positive syphilis serology in patients with a previous history of syphilis.
- Past medical and surgical history where relevant (specifically obstetrics and gynaecology)
- *Rationale:* to identify conditions that may be associated with or influence the management of STIs and reproductive health needs.
- HPV vaccination history in women born after 1995, men born after 2006, and MSM between the ages of 20 and 45 years[iii]
  Rationale: to facilitate access to vaccination of those eligible if not started or not completed.

- Family history
  Rationale: to determine eligibility and contraindication for contraception according to UKMEC.[39]
- Drug history and history of allergies
  All patients should have a history of current medication taken, including over-the-counter remedies and those bought on the internet, 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 including Chemsex[iv]
  Rationale: alcohol and recreational drugs are a major factor in sexual risk taking.[40–46] Screening tools such as FAST and AUDIT[40–46] are quick and simple to do. Some services will screen and undertake Alcohol Brief Interventions.
- Smoking history
  Rationale: modifiable risk factor for several poor health outcomes including cervical cancer and alters eligibility (UKMEC) status for some contraceptives[39]
- Identification of unmet need about difficulties with sexual performance and satisfaction
  Presentation related to psychosexual problems is common in people attending sexual health settings.[47] Erectile dysfunction is associated with increased acquisition of STIs and non-use of condoms.[48]
  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.[49–52]
  Rationale: provision of support and access to referral pathways. The Department of Health and Social Care has produced a toolkit to help practitioners manage IPV. NICE has produced Public Health guidance on preventing and reducing IPV.[52] Routine enquiry about current and historic GBV aims to detect people who may be at risk of further ongoing violence and alerts practitioners to consider their safety. This is mandatory in sexual health services in Scotland.[51]
- Pregnancy Risk
  Individuals where there is the potential for pregnancy (including trans men and non-binary [assigned female]) people, if they have not undergone hysterectomy or bilateral oophorectomy, who are having vaginal sex with a risk of pregnancy and do not wish to conceive should have a discussion regarding pregnancy planning and contraceptive needs.[53] (1, D)
  This should include an assessment for risk of pregnancy with appropriate support and management; for example, emergency contraception, referral for termination of pregnancy or advice on healthcare in pregnancy and in the post-partum period.

  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 support individuals in the decision-making process and refer appropriately and in a timely manner

- Contraception history
  Individuals not using contraception and not planning a pregnancy should have a contraception consultation, where all methods are discussed including LARC and the UKMEC used to guide choice according to eligibility. Individuals using a method of contraception should be asked about satisfaction with their current method and any side-effects or concerns they may have.[39]
  Rationale: provides opportunities for information giving, motivational interviewing,[54] to improve concordance and satisfaction and to offer a more effective method of contraception i.e. LARC.

  Cisgender 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

  Transgender patients:

  - Guidance and specific information on contraception options for transgender and non-binary patients can be found in the FSRH consensus statement on contraceptive choices for transgender and non-binary people and their partners and the BASHH recommendations for integrated sexual health services for transgender individuals.[53]

- History of unusual or altered vaginal bleeding.
  The FSRH guidance deals with problematic bleeding in women using hormonal contraception, including points to cover in the clinical history, as well as management.[55]
  Rationale: unusual vaginal bleeding may be due to cervical pathology and should prompt a cervical examination and a potential urgent colposcopy clinic referral. Also, to carry out an STI risk

assessment or exclude contraceptive methods as a cause of irregular bleeding. It may also promote discussion for individuals in the perimenopausal period who may need referral to a specialist clinic to manage their specific needs.

- Obstetric history, including outcomes and complications
  Rationale: part of the assessment of reproductive and sexual health that may impact on the current presentation, assessment, examination and screening or the need to screen children or close contacts.
- Assessment of other symptomatology such as cyclical mood disorders, pelvic pain, dysmenorrhoea or menorrhagia which may indicate underlying gynaecological pathology such as premenstrual dysphoric disorder (PMDD), endometriosis, polycystic ovary syndrome (PCOS) or fibroids
  Rationale: More complex symptoms may need further investigation and individuals should be appropriately referred into secondary care or for further investigations.
- Cervical smears
  Individuals who have a uterus, including trans men and non-binary people (assigned female at birth), should be asked about the following: (1, D)
    - If they are participating in the NHS Cervical Screening Programme, when their last test was taken (if aged over 25 years), the result and if they have received treatment before. (1, D)

  Rationale: to include in the risk assessment and determine if a test should be performed or whether referral is necessary. An opportunity for health promotion including smoking cessation advice and HPV vaccine recommendation.

3.5 Risk assessment for blood-borne viruses.

Recommendation: As part of a comprehensive history, patients should be asked about the following (1, D):

- Current or past 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 (1, D).
  Rationale: to identify the need for hepatitis B, hepatitis C and HIV testing and hepatitis A and B vaccination.[56,57]
- Sex with a partner from or in a country with a high HIV prevalence.
  Rationale: to identify sexual partners at higher risk of HIV (1, D).
- HIV testing history[56]
  Rationale: to determine whether HIV testing is appropriately timed.
- Previous use of HIV PEP and PrEP
  Rationale: Previous use of HIV PEP and PrEP indicates past risk and risk reduction and also allows for information to be given where appropriate.[58,59]
- Sex with cisgender MSM and transgender women. Cisgender MSM and transgender women have been shown to be at higher risk of blood borne virus acquisition. Patients should be asked if they have ever had sexual contacts from these risk groups.
  Rationale: to identify the need for hepatitis B, C and HIV testing and hepatitis A and B vaccination[56,57] and offer risk reduction advice. (1,D)
- Hepatitis B risk. MSM, sex workers (of any gender), PWID (including people who inject steroids, other performance enhancing and 'recreational' drugs ['slamming']), people living with HIV, sexual assault victims, people from countries where hepatitis B is endemic (outside of Western Europe, North America and Australasia), needlestick victims, heterosexuals with >10 partners/year and sexual partners of hepatitis B positive or high-risk patients.[57] (1, D)
  Rationale: identification requires serological testing of hepatitis B and vaccination and allows risk reduction counselling.

3.6 Sexualised drug use, including Chemsex.

Recommendation: Clinicians should be able to identify and manage patients who have problematic substance misuse, particularly when it impacts on their (or others') sexual health. (1,B)

Clinicians should be aware of the commonly used drugs and their potential short- and long-term complications and risks. Simple safety advice should be given.

Recommendation: Appropriate local referral pathways should be established. (1,B)

Rationale: Sexualised drug use, including Chemsex is the use of drugs before or during sexual activity to sustain, enhance, disinhibit or facilitate the experience should be routinely assessed as part of the sexual history.[60,61] A small number of questions can be asked to identify substance use, and whether it is likely to be problematic and/or impact on sexual health.[60]

Chemsex is a risk factor for enhanced sexual risk taking. One in five 16–24 year olds have used an illicit drug in the last year and three quarters of MSM.[60]

Often multiple drugs are used during a single session which may extend over days, and there is evidence of increasing levels of injecting (known as 'slamming' amongst many MSM) and sharing equipment.[60] For MSM extended sessions taking these drugs also often involve higher risk sex with multiple partners.[60] A significant proportion of MSM using these drugs are living with HIV but by no means all.

Drug Use Screening Tool:[60]
Have you used drugs in the past 12 months?
Which ones?
Did you inject them? If so, did you ever share equipment?
Are you, or anyone close to you, worried about your drug use, or think it may be having a bad effect on you or your health?

3.7 Closing the sexual history. *Recommendation: After the sexual history is completed, the health care practitioner should (1, D)*:

- Check with the patient that they have no other concerns that have not yet been discussed.
- Explain the need for, and nature of, a clinical examination and tests.
- Give the patient the option of a chaperone for the examination.[22,25,26]
- 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.[62–66] 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 (1, D):

- The record keeping of a sexual history should be in keeping with national standards of practice.[62–66]
- 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, probably most, record the sexual history on proformas with a locally-agreed dataset. These may:

- Assist timely record keeping
- Make history taking more systematic
- Reduce the chance of omitting important pieces of information
- Facilitate audit[23,67]

Recommendation: Services should consider the range of data items in the light of their local and national health priorities and needs (1, D).

For example, in Scotland, routine enquiry about gender-based violence was mandated in sexual health services in 2008[51] and a national minimum data set for all sexual health services was agreed in October 2011 to replace the STISS coding system.[68]

4.3 Electronic patient records (EPR). Most services now use clinical information systems. These range from simple demographic registers to fully-fledged bespoke sexual health paperless electronic record systems. Services implementing electronic record systems need to ensure 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.[67] This is relevant to sexual health clinic settings. The advantages of EPR in the sexual health setting are now well recognised.[69–71]

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.[72] 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.[73]

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.[74] 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.[74] *(1, D)*

Safeguarding children

Recommendation: 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.[74–77] *(1, D)*

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 services and the police may be indicated but is not mandatory.[74–77] 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.[77]

5.2 Taking a sexual history in the outreach setting. Outreach clinics, either run by SH/SRH clinics or which have been devolved to other providers, bring sexual health services out of traditional settings. There is a specific national guideline for the management of STIs in primary care[78]

Recommendation: The following factors should be considered when taking a sexual history in an outreach clinic (1, D):

- 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.[23]
- All services be provided in a comfortable environment that supports the patients' confidentiality and dignity.[23,24]
- Specific consideration should be given to security measures for the protection of staff working in remote sites or in out-of-hours services.[23,24]
- Chaperoning for the medical interview and examination should be available and offered to all patients.[22,25,26]
- 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.[23] The use of an electronic patient record is recommended as this is more secure and minimises the transfer of paper records

5.3 Women identified with Female Genital Mutilation (FGM).
Recommendation: Enquiring about whether FGM has been previously performed should be routine for all consultations with women. (1,C)

When FGM is identified to have taken place, a standard FGM consultation template should be used which collects the following information (1,C):

- Type of FGM (grade 1–4) and any complications of the procedure
- Age when performed
- Where performed
- Has it been reported to police/social services if girl is under 18?
- Any other family members with FGM
- Any children in the family at risk of FGM
- Woman's knowledge of the law on FGM and attitudes to the practice
- Family's attitude to FGM
- Knowledge of support services and access to surgical reversal.

Rationale: FGM has been illegal in the UK since 1985 and in subsequent legislation in 2003 (England, Wales and Northern Ireland)[79] and in Scotland (2005).[80] This was further updated in England in the Serious Crimes Act (2015)[79] to include FGM performed on UK

residents whilst abroad and failing to protect a girl from risk of FGM. In England and Wales professionals now have a duty to inform the police of girls with FGM under the age of 18 as well as following safeguarding procedures for the child. In addition, in England there is an FGM Enhanced Dataset for healthcare providers to report to,[81] although sexual health services are exempt. Scotland has a national action plan to prevent and eradicate FGM in sexual health services.[82] It is good practice to record any FGM identified, even in women 18 years and over as a means of identifying any health needs in that woman and identifying any children in the family who may be at-risk for FGM.

5.4 Consultation skills when not 'face-to-face'. There has been a rapid expansion in providers of online SH/SRH services. These include a range of modalities from real-time interactive health care via a video link, to web-based questionnaires.

It is recognised that many patients will choose to test via a remote or online service for multiple reasons; i.e. anonymity, time or cost. While BASHH support these developments they strongly believe that, irrespective of consultation modality, best practice and guidelines must be adhered to at every user contact to ensure safety and quality of care. They have recently published a joint set of standards with the FSRH which broadly sets out a set of 'best practice' standards for providers of remote and online SH/SRH services.[83]

Recommendation: Service providers should be aware there are obstacles to consulting via remote means. For example, with a telephone consultation, physical symptoms or demeanour cannot be assessed. Similarly, an online questionnaire is not a two-way process meaning uncertainties cannot be clarified and follow-up questions cannot be asked.[84]

There are also difficulties in assessing service users with vulnerabilities; such as young age, people with mental health problems, adults who lack capacity, those with complex medical histories, polypharmacy, or where there may be a need to break bad news or complex ethical issues.

It is recommended that in these or other circumstances where a concern may be raised, a user should be signposted into the local SH/SRH service for a face-to-face consultation. (1, D)

6. Applicability

This guideline should apply to sexual history taking within 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 nine areas of the sexual history components in Section 3. Target 97%
2. Proportion of new/rebooked patients having a record relating to all four 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 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. NICE have published quality standards that should be used as a basis of audit.[85]

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Notes

i. These are the age groups eligible at the time of writing although may change in the future.
ii. Examples of open questions include 'how can I help you today?' or 'what brings you here today?'
iii. These are the age groups eligible at the time of writing although may change in the future.
iv. Chemsex is the use of drugs, particularly methamphetamine, GHB/GBL and mephedrone, before or during planned sexual activity to sustain, enhance, disinhibit or facilitate the sexual experience.

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Appendix 1. GRADE scoring system for recommendations used in this guideline

Strength of recommendation

1 = strong or 2 = weak. Pragmatically this means the following:

Strong recommendation for intervention

For patients – most people in this situation would want the recommended course of action and only a small proportion would not

For clinicians – most people should receive the intervention

For quality monitors – adherence to this recommendation could be used as a quality criterion or performance indicator. If clinicians choose not to follow such a recommendation, they should document their rationale

Weak recommendation for intervention

For patients – most people in this situation would want the suggested course of action, but many would not

For clinicians – examine the evidence or a summary of the evidence yourself and be prepared to discuss that evidence with patients, as well as their values and preferences

For quality monitors – clinicians' discussion or consideration of the pros and cons of the intervention, and their documentation of the discussion, could be used as a quality criterion.

Strength of evidence:

A: A body of evidence of high quality meta-analyses, systematic reviews of and RCTs directly applicable to the target population

B: As above but relating to high quality case control or cohort studies with low risk of bias or confounding and high probability that a relationship is causal

C: As B but trials may have some flaws

D: Non-analytic evidence, e.g. case reports or series or expert opinion