

Yes, the sexual history IS important

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Primary care practitioners repeatedly admit that they seldom ask patients about their sexual practices when taking a history.¹ They are reluctant to address sexual health issues for several reasons, including embarrassment, feeling ill prepared, existing time constraints, and a belief that the sexual history is not relevant to the chief complaint.² When clinicians convey discomfort with sexual problems, patients become uncomfortable too; they report that this discomfort is the primary barrier to discussing sexual health issues during the health care visit.²

Medical practitioners and behavioral scientists feel that a practitioner's comfort when taking a sexual history holds the key to the practice of sexual health medicine and provides the basis for prevention, education, and sexual health promotion.^{3,4} How important is eliciting a sexual history? There is an increasing consensus in the public health community and in the medical community that primary care providers should play a more important role in modifying high-risk sexual behaviors.⁵ Numerous agencies, including the US Preventive Services Task Force, the American Academy of Pediatrics, the American Medical Association, and the Bureau of Maternal and Child Health, have recommended that primary care practitioners improve their assessment of the high-risk sexual behavior of all adolescent and adult patients.^{1,5}

In order for practitioners to provide appropriate prevention messages to patients, they need to possess the skills to determine who is at increased risk for sexually transmitted infections (STIs), including HIV.^{4,6} Determining whether a patient is at high risk for STIs and HIV infection may be difficult because both the practitioner and the patient might be uncomfortable with questions regarding sexual practices and drug usage. Simply including these questions in a written questionnaire that the patient fills out before seeing the practitioner is often not sufficient. Many persons at risk are unwilling to reveal personal information about themselves in this fashion.⁷ Face-to-face questioning by the practitioner about sexual risk behavior may do a better

job of identifying those patients who are at risk for STIs and HIV. Practitioners who fail to incorporate risk assessment into each health care encounter may not be able to identify patients who would benefit from early intervention.⁸

Timely identification of HIV infection is critical from both the clinical and public health perspectives.⁹ Early identification of persons infected with HIV provides the opportunity to reduce the transmission of the virus through counseling about how to change risk behavior and to initiate early treatment with highly active anti-retroviral therapy (HAART), thereby reducing viral load, which may reduce infectivity.¹⁰ This reduction in infectivity has a public health benefit in that it further reduces transmission.¹⁰

Since the beginning of the AIDS epidemic, most of those identified as being at risk for HIV-1 infection in the United States have been men who have sex with men and injection drug users. However, over the past 15 years, the HIV infection rate among heterosexual women has steadily increased. In 2002, CDC surveillance data demonstrated that heterosexual transmission accounted for most of the AIDS cases reported among US women and particularly affected women of color in the

Suggested questions to ask during the sexual history

- Are you sexually active? When was the last time you had sex?
- Do you have sex with men, women, or both?
- Did you use a barrier the last time you had sex? How often do you use a barrier when you have sex?
- Do you engage in oral, anal, or vaginal intercourse?
- Are you the insertive partner, the receptive partner, or both?
- Was the sexual encounter consensual or nonconsensual?
- Have you ever paid for sex (exchanged sex for drugs or exchanged sex for money)?
- Have you ever been a resident in a correctional facility?
- Do you have a history of sexually transmitted diseases?
- Has your judgment ever been impaired by the use of alcohol or drugs?

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CDC screening recommendations

- All sexually active females younger than 25 years who visit their health care providers for any reason should be screened for chlamydia and gonorrhea at least once per year.
- All young, sexually active men should be screened routinely for chlamydial and gonococcal infections in settings or subpopulations in which the prevalence of these infections is greater than 2%.
- All others should be screened yearly if they are considered to be high risk.

Source: Sexually transmitted diseases treatment guidelines 2002. *MMWR*, May 10, 2002;51(RR-6). Available at: <http://www.cdc.gov/mmwr/PDF/rr/rr5106.pdf>. Accessed November 7, 2005.

southern United States.¹¹ The rate of AIDS diagnoses among African-American women is 48.6 per 100,000, and among African-American women aged 25 to 44 years, AIDS is the second most frequent cause of death.¹¹ Hispanic women of the same age group have the second highest mortality rate from AIDS.¹¹ Limited research data suggest that the character and dynamics of women’s sexual relationships may be important determinants of risk, both for engaging in risk behaviors and for doing so with high-risk partners. All of these new developments indicate a need for the primary care provider to be able to elicit a thorough sexual history and identify patients at risk for STIs and HIV.

A new sexual health strategy is needed—one that advocates effective treatment of symptomatic conditions, improvement in knowledge and awareness of asymptomatic conditions, and reduction of the stigma associated with STIs and HIV.⁴ Seven principles involved in taking a sexual history that promote patients’ and practitioners’ comfort during the interview are

- Ensuring privacy and confidentiality
- Being professional
- Being open-minded and nonjudgmental
- Recognizing nonverbal cues
- Asking only appropriate questions
- Explaining procedures and treatments thoroughly
- Using the time to promote risk reduction and sexual health.⁴

Experience and skill in taking a sexual history can encourage patients to reveal the intimate details of their private lives that are necessary to determine the choice of examination, laboratory investigation, diagnosis, follow-up, and contact tracing.¹² A skilled practitioner should be able to obtain a sexual history from a patient in minutes.⁶ The information gained can be used to stimulate a conversation with the clinician that provides information, counseling, and support to the patient. The well-prepared and trained practitioner is sympathetic

TABLE

Persons at high risk for STIs and HIV

- Abusers of substances including alcohol and recreational drugs
- Commercial sex workers
- Long-distance truck drivers
- Military recruits
- Persons already infected with HIV
- Persons incarcerated in (or recently released from) correctional facilities
- Persons who have more than one sex partner per year
- Persons with a history of sexually transmitted infections
- Residents of a community with high rates of sexually transmitted infections

and understands the sensitivity with which questions must be asked and information transmitted.¹³

In summary, sexual histories are important, and practitioners should be able to identify patients at risk for STIs and HIV. They should be able to encourage testing while reinforcing risk reduction activities for all patients. The primary care provider should be able to provide an explanation of the benefits of early identification of and early intervention for STIs and HIV. To accomplish this, the practitioner must overcome the existing barrier of feeling uncomfortable while eliciting a sexual history.² □

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