

Virtual Mentor

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Medical Education

Why Do We Take a Sexual History?

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During my training in adolescent medicine, one of my preceptors posed this question to me, “If you ask *that* question, what will you do with the answer?” Taking a patient’s sexual history is a situation in which we should be mindful of why each question is being asked and what action will follow from the answer.

Taking a sexual history from adults and adolescents is a necessary first step toward providing contraceptive, reproductive, and sexually transmitted disease (STD) counseling. A sexual history screens for high-risk sexual behaviors, may identify sexual problems, and is an opportunity to provide information and support to patients. Statistics illustrate that having sex is not a rare event for adolescent and young adult patients. In a national survey of high school students, nearly half (46.7 percent) reported having had sexual intercourse [1]. Between 800 000 to 900 000 adolescent females under the age of 19 become pregnant every year [2]. Sexually transmitted diseases are also a concern. Chlamydia and gonorrhea rates are highest among females aged 15-19 years old and males 20-24 years old [3,4].

Who should we screen?

Many high-risk-taking behaviors begin in adolescence. In fact, 7.4 percent of teens have had sex before the age of 13 years [1]. Despite this, researchers found that “clinicians were less likely to screen younger adolescents than older adolescents” [5].

At the other end of the life cycle, some health care professionals assume that older adults are sexually inactive and fail to assess their sexual health. Older adults are at risk for sexually transmitted infections and may be less forthcoming about sexual problems [3,4,6-9]. In a study of sexual activity among older adults, 31 percent of men and 43 percent of women reported sexual dysfunction [9]. In the Massachusetts Male Aging study, 52 percent of men 40 to 70 years old experienced erectile dysfunction [10].

Unfortunately, studies show low rates of sexual health assessment by physicians and other health care professionals [11]. Time constraints, underestimation of patient risk, and embarrassment prevent some clinicians from conducting this assessment [11-15]. Others may not believe that a sexual history is medically relevant to the visit, while still others are unfamiliar with some sexual practices and avoid the topic entirely [14].

In the case of adolescent patients, many clinicians fear that teens will disclose sexual activity, initiating a cascade of questions to assess pregnancy and STD risk. This may lengthen the visit and raises issues of confidentiality, parental involvement and

knowledge, and changing risk-taking behaviors. With older patients who may be their parents' or grandparents' age, some young physicians are uncomfortable asking questions about sexual dysfunction or satisfaction [14].

Do patients want to be asked about sex?

Patients who do not discuss their sexual health with clinicians often wish they had and that the discussion had been part of a routine exam [16,17]. Most adolescents believe it is important to discuss sexual intercourse, contraception, pregnancy, unwanted sexual activity, and sexually transmitted diseases [17].

Are physicians trained to do a thorough sexual history?

Many graduating clinicians do not feel adequately prepared to evaluate sexual health problems [17]. Older physicians report less STD assessment training during medical school and residency than do younger physicians. However, training in sexual history assessment may be increasing in medical school education [18,19], and students who have had sexuality/sexual health instruction report greater confidence in addressing this topic with patients [20.] Physicians who conduct sexual histories are also more likely to test patients for STDs [21,22].

When should a sexual history be taken?

Often a sexual history is obtained when a patient presents with a specific symptom such as vaginal discharge, but opportunities aside from problem-focused visits exist and should be acted upon. Early adolescents and older adults should receive sexual health screenings at their check-ups, well visits, or preventive health visits. A sexual history may be obtained during the review of systems or during the personal and social history. The Guidelines for Adolescent Preventive Services (GAPS) screening tool, available online, assesses several risk factors including sexual activity and can be given to adolescent patients before the physician enters the room [23].

Elements in a Sexual History

The following is a list of elements that are essential to taking a good sexual history. Many other sources exist for detailed examples of sexual risk assessment questions [12,24-28].

1. Confidentiality: Establish a safe and comfortable environment to discuss personal health issues. At the beginning of the visit, emphasize patient confidentiality and its limits [29].
2. Patient concerns: Ask open-ended questions. This may help begin the discussion, but you also may have to ask specifically about sexual problems or concerns. Many patients want to ask questions but won't unless given the opportunity.
3. Sexual orientation and preferences: It is important not to assume heterosexuality when obtaining a sexual history [30]. Many primary care physicians learn about sexual orientation when the patient spontaneously

discloses [14]. This question can be prefaced by stating “I ask this question of all of my patients: are you interested in men, women, or both?”

4. Age of sexarche: Younger adolescents who are in relationships with older partners know less about pregnancy prevention and STDs, and are at greater risk of being coerced into sexual activity and becoming pregnant [31-33].
5. Types of sexual practice (oral, anal, vaginal): Elicit information about sexual behavior and types of sexual practice in the assessment for STD risk and presentation (eg, vaginitis, pharyngitis, proctitis).
6. Last sexual intercourse: The date of the most recent sexual encounter is important for pregnancy and contraceptive counseling as well as for STD treatment and prevention.
7. Sexual partner assessment: The number of lifetime partners, number of partners in last 6 months, nature of the relationship (eg, serial monogamy versus one-time events, ability to negotiate use of condoms or birth control devices), and intimate partner violence screening are part of STD risk assessment.
8. Pregnancy prevention or desires: It is important to understand the patient’s desires regarding pregnancy, so that counseling is consistent with his or her goals, and information and advice is appropriate.
9. History of prior pregnancies and outcomes: Again, this is helpful in contraceptive and reproductive counseling to identify risk and needs.
10. STD prevention practices: Inquire about condom usage (eg, consistency, correct use, access), regular STD testing, and reduction in number of partners.
11. STD symptoms: Recognize that patients may be asymptomatic, and use the assessment to provide education regarding STDs.
12. History of prior STDs: Eliciting this history is an opportunity to discuss how to prevent future STDs, potential infertility and to assess STD risk.
13. Problems related to sexual intercourse.
14. History of sexual abuse.

Not every question need be asked at the initial visit; some may be reserved for subsequent visits. If patients realize that a sexual history is part of a routine exam, they may be more comfortable raising questions or concerns in the future. Also, if patients see their clinicians sensitively and comfortably asking these questions, they may view them as a resource for sexual health information.

Medical Education and the Sexual History

Learning how to take a sexual history should be part of medical education. It can be integrated into the curriculum in several ways:

1. Students should have opportunities to take a sexual history in inpatient and outpatient settings.
2. Faculty should demonstrate how to take a sexual history.
3. As medical schools incorporate sexual history taking into curricula, an evaluation of students' skills, comfort with, and frequency of taking sexual histories should be made as well as an evaluation by patients about how the sexual history was obtained.
4. For those students and physicians who are uncomfortable obtaining a sexual history, increased experience in asking sensitive questions about sexual health practices and beliefs may decrease anxiety in asking these questions.

Understanding our own feelings about diversity in sexuality and sexual health across the lifespan will help us communicate with our patients about these issues.

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