Sexual history and examination in men and women

Sophie Herbert

Abstract

Taking a sexual history and undertaking a genital examination are not skills regularly used in general medicine. While the structure and process of history-taking and clinical examination follow that seen in other medical specialties, aspects unique to taking a history that covers intimate subject matter require additional empathy, sensitivity and non-verbal skills, to enable clinicians to obtain the information needed to undertake an appropriately thorough assessment. This article aims to simplify sexual history-taking and examination, providing tips on how to do it well.

Keywords Examination; history; men; MRCP; safeguarding; sexual health; women; young people

Key points

- Taking a useful sexual history relies on good communication skills (verbal and non-verbal), rapport between patient and clinician and a non-judgemental approach
- Confidentiality is essential
- Genital examination should be systematic, and an explanation of the process should be given before the examination. A chaperone should always be offered

Introduction

The aims of taking a sexual history are to:[1]

- establish possible risks for sexually transmitted infections (including blood-borne infections), enabling correct patient advice and facilitating health promotion
- identify information that might highlight a diagnosis, which can include assessment of other health issues such as psychosexual problems by appropriately trained staff
- establish which tests are appropriate and which sites should be sampled.

Taking a patient's sexual history can be embarrassing for both clinician and patient. The priority is to try make the process feel more normal so the patient is at ease and able to disclose the necessary information. It is essential that this is done in a non-judgemental manner. Failure to do this can alienate the patient and any subsequent interactions, which can make giving results and further management difficult for both parties. It is important for clinicians to be aware of their own attitudes to sexual behaviour and recognize that this has the potential to affect the ability to undertake effective history-taking.

Confidentiality

Confidentiality is paramount when dealing with matters of sexual health, and patients are to some extent expecting to be asked sensitive questions. Confidentiality should also be observed in other settings, although this can be problematic depending on the environment: taking a sexual history in a busy accident and emergency department with only a curtain to screen patients is unlikely to yield as useful or accurate information as a closed private room. In some situations, it can be better to defer history-taking if clinically appropriate until a private soundproof space can be found. Patients should be interviewed on their own, and students and observers should only be present with the patient's consent.

The patient needs to know that their information will be treated in the strictest confidence in accordance with General Medical Council guidance.[2] It is particularly helpful when talking to young people to explain the limits of this confidentiality at the start of the consultation, so that if safeguarding concerns arise, or the patient or another person is considered to be at risk of harm, the young person is already aware that information may need to be shared.

Communication skills

Excellent communication skills are essential when taking a sexual history because of the sensitive nature of the subject matter. The clinician's non-verbal cues are important, including use of appropriate body language, maintaining eye contact (where culturally acceptable) and recognizing patient cues that might indicate anxiety and distress. Initial use of open questions is helpful to establish rapport and trust between patient and clinician. It is also useful to explain the rationale for particular questions to set the context for the patient.

Safeguarding and mental capacity

All clinicians undertaking a sexual history should be mindful of safeguarding issues and alert to 'spotting the signs' of child sexual exploitation and other vulnerability factors. Taking a sexual history often engenders trust between clinician and patient, enabling disclosures to take place. Concerns of domestic violence, adult and child safeguarding issues and mental capacity should be escalated and referred accordingly. Where information needs to be shared, this should be explained to the patient to maintain trust, but safety remains paramount. If in doubt, advice should be sought from the local safeguarding team.

Structure of history-taking

The structure of sexual history-taking is the same for men and women, but specific system-based questioning varies according to the patient's sex. Be mindful of transgender patients and sensitive to their needs.[3]

Sophie Herbert *MBChB MSc MRCP Dip GUM Dip HIV DFSRH is a Consultant Physician at Northamptonshire Healthcare NHS Foundation Trust, Kettering, UK. Competing interests: none declared.*

Please cite this article in press as: Herbert S, Sexual history and examination in men and women, Medicine (2018), https://doi.org/10.1016/j.mpmed.2018.02.005

The basics of history-taking are similar to those in other specialties:

- presenting complaint
- history of presenting complaint
- past medical history
- for women, gynaecological history (including previous pregnancies, current and past contraception, cervical cytology and results)
- drug history
- allergies
- sexual history
- social history.

Certain information about sexual partners and type of sexual activity is necessary to enable the clinician to undertake an appropriate assessment. Equally, some personal and probably sensitive information is not necessary to complete their evaluation.

Sexual history

The type of detail that is required from the history varies depending on whether the patient is asymptomatic or symptomatic. There are, however, questions that should be routinely asked; these and the rationale behind them are listed in Table 1.

Other questions now commonly asked in clinics concern lifestyle behaviours that can affect sexual risk-taking, for example use of alcohol, smoking and in particular recreational drugs. In some sexual encounters, recreational drugs play a large part in increasing risk behaviour, such as in 'chemsex'; being aware of this enables exploration of sexual risks and the offer health promotion such as encouraging safer sex and condom use, regular STI testing and discussion of support available for those with problematic drug and alcohol use.

How to ask sensitive questions

It is helpful to introduce your questions with the reasons for asking that question, for example 'I need to ask about the type of sex you have with your partners so I can do the right tests.' Clinicians new to sexual health often experience difficulties finding the right ways of asking the sensitive questions needed for a sexual history. It takes time to find a way that is comfortable for both clinician and patient:

Presenting complaint

Symptoms can vary. Patients may, for example, state:

- 'I just want a check-up'
- 'I noticed some pain when passing urine'
- 'I have a new discharge that is smelly and uncomfortable.'

Many patients present with some of the symptoms listed in Table 2. If these are not mentioned initially, it is sensible to check for them in a symptom review.

History-taking in sexual health practice

Examples of questions to be asked	Rationale
'When did you last have sex?'	To establish the timing of sex in relation to testing and: • Inform the patient of the need for repeat testing if still in the 'window period' • Consider whether emergency contraception is necessary for women • Consider whether post-exposure prophylaxis for HIV is needed
'Who was that with?' • Regular partner or casual partner? • Length of relationship • Men, women or both?	To facilitate partner notification To identify men who have sex with men offer rectal and pharyngeal samples, and offer hepatitis screening and vaccination To identify transgender/non-binary individuals (see LGBGT sexual health, p. xxxx (10.1016/j.mpmed.2018.02.004))
'What type of sex did you have?' (oral, vaginal, anal, giving/receiving)	To identify sites to be sampled
'Were condoms used?' (always, sometimes, never)	To undertake risk assessment and facilitate condom promotion
'When did you last have sex with someone different?'	To establish timing of tests in relation to window periods to enable correct advice to patient
'How many partners have you had in the past 3 months?'	To assess risk, information to be collected as above
Screening for blood-borne viruses. History of: • Injecting drug use • For men — any previous male partners • Other risk factors, e.g. exposure to blood products before screening or abroad, tattoos, contact with sex workers • Contact with anyone known to have HIV or hepatitis B or C	To assess risk and enable testing To offer hepatitis (B, C) screening and hepatitis B vaccination where appropriate
'Have you had any sexually transmitted infections in the past?'	To establish risks, and whether treatment was completed and partner notification previously undertaken

Table 1

Please cite this article in press as: Herbert S, Sexual history and examination in men and women, Medicine (2018), https://doi.org/10.1016/j.mpmed.2018.02.005