FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

Sexually Transmitted Infections Screening Form

Youth:	DJJ ID:
Date/Time: /	Facility:

	Yes	No	Don't Know
1. Have you ever had vaginal, anal or oral sex without using protection? If yes, when was the last time that you had unprotected sex? _____	☐	☐	☐
2. Have you ever been tested for (sexually transmitted infections) STI's or HIV? ☐ Never Tested/Unknown ☐ Yes-Date and Location:			
3. Have you ever put drugs of any type in your veins or shared needles?	☐	☐	☐
4. Have you ever had any type of infection of your sex organs?	☐	☐	☐
5. Has the use of alcohol or any drug caused you to do things sexually that you would not normally do?	☐	☐	☐
6. Some teens use sex to get things that they need. Have you ever had to do this?	☐	☐	☐
7. Have you ever been hit, kicked, slapped, pushed or shoved by your sexual partner?	☐	☐	☐
8. Have you recently been sexually assaulted?	☐	☐	☐
9. Some females / males prefer to have sex with males, some with women and some with both. What type of partner do you prefer? *(Please Check One)* ☐ Men ☐ Women ☐ Both			
10. As far as you know, have you ever had sex with someone who had HIV/AIDS or an STI?	☐	☐	☐
11. As far as you know, have you ever had sex with someone who was a man who had sex with men?	☐	☐	☐
12. As far as you know, have you ever had sex with someone who used IV Drugs or put drugs in their veins?	☐	☐	☐
13. As far as you know, have you ever had sex with someone who was a prostitute - either male or female?	☐	☐	☐
14. Do you have any concerns related to your genital area?	☐	☐	☐

My signature confirms that I have truthfully answered these questions to be the best of my knowledge.

Youth Signature _____ Date _____

Orders obtained for testing prior to being evaluated by a practitioner? ☐ *No* ☐ *Yes-See Practitioner Order/Protocol.*

Person Completing Form's Signature and Title _____ Date _____

Screening/test results, if completed/available, were reviewed by DHA? ☐ *Yes* ☐ *No* ☐ *N/A*

Need for further evaluation/treatment? ☐ *No* ☐ *Yes-See plan of care/Practitioner Orders*

Physician/Designee Reviewer Signature _____ Date _____

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