Original Article

Sexual dysfunctions in young university women: a cross-sectional study

Disfunções sexuais em mulheres jovens universitárias: estudo transversal

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ABSTRACT | OBJECTIVE: To estimate the prevalence of sexual dysfunction in young college women. **METHODS:** This is a descriptive-analytical cross-sectional study. A total of 111 heterosexual women students of the physiotherapy course from the Universidade Federal da Bahia participated in this study. Each participant answered two self-administered questionnaires, "Investigation of associated factors" and "Sex ratio - female version" between September and October 2019. **RESULTS:** A prevalence of 8% of sexual dysfunction was found in this population. The symptom of evacuatory effort was associated with worse performance / sexual satisfaction by the total SQ-F score (p=0.03), and when assessed by a grouping of questions, an association was found between evacuatory effort and worse arousal (p=0.01), evacuatory effort, and pain (p=0.04); urinary urgency and pain (p=0.04); violence and arousal (p=0.05); and violence and less satisfaction/orgasm (p=0.02). **CONCLUSION:** The results suggest a low prevalence of sexual dysfunction in the studied population, but there is an association between symptoms of pelvic floor dysfunction and sexual dysfunction in young women.

KEYWORDS: Physiological Sexual Dysfunction. Sexual Disorders. Sexual health. Young adult. Risk Factors.

RESUMO | OBJETIVO: Verificar a frequência e os fatores associados à disfunção sexual em mulheres jovens universitárias. **MÉTODOS:** Trata-se de um estudo descritivo analítico de corte transversal. Participaram deste estudo 111 mulheres, estudantes, heterossexuais do curso de fisioterapia da Universidade Federal da Bahia. Cada participante respondeu a dois questionários autoaplicáveis "Investigação de fatores associados" e "Quociente sexual – versão feminina", entre os meses de setembro e outubro de 2019. **RESULTADOS:** Foi encontrado nesta população prevalência de 8% de disfunção sexual. O sintoma de esforço evacuatório esteve associado a pior desempenho/satisfação sexual pelo *score* total do QS-F (p=0,03), e quando avaliado por agrupamento de questões, foi encontrada associação entre esforço evacuatório e pior excitação (p=0,01), esforço evacuatório e mais dor (p=0,04); urgência urinária e mais dor (p=0,04); violência e pior excitação (p=0,05) e violência e menos satisfação/orgasmo (p=0,02). **CONCLUSÃO:** Os resultados sugerem que há baixa prevalência de disfunção sexual na população estudada, mas há associação entre sintomas de disfunções do assoalho pélvico e disfunções sexuais em mulheres jovens.

PALAVRAS-CHAVE: Disfunção Sexual Fisiológica. Distúrbios sexuais. Saúde sexual. Jovem adulto. Fatores de risco.

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Introduction

Adequate sexual function and satisfaction set the pillars of quality of life, thus being an essential element for the integral health of women.[1] It is known, however, that for cultural reasons, for a long time, this issue was ignored by the scientific community and society in general. Only recently the female sex life has been taken into account when it comes to health and quality of life.[2]

Currently aware of the importance of sexual health for the exercise of full health, the processes involving female sexual function are being increasingly discussed. A model recently proposed by Basson suggests that the adequate function occurs as a cycle, which is directly influenced by extrinsic, intrinsic, and interpersonal factors, in variable order and considering the individual-individual and individual-situation relationship.[3]

These reflections make it possible to observe sexual function more broadly, based on each response phase, and consider personal and social factors, such as desire, interest, foreplay, personal arousal, and attunement with the partner.[4] Thus, it is possible to expand the definitions of sexual dysfunction (SD) and, consequently, the aspects for these conditions' diagnosis and treatment.[5]

SD is characterized as the inability to participate in sexual activity with satisfaction.[4] Several studies have been developed in areas related to female sexual function and dysfunction. Currently, the data points to a prevalence of at least one SD in about 49% of the Brazilian female population.[5]

That being a function liable to intrinsic-extrinsic-environmental influences, all factors related to improper functioning must be taken into account. Some risk factors for SD are already known, such as the co-occurrence of other disorders, history of trauma (accidents, violence, abuse), obstetric history, hormonal changes, sociodemographic characteristics, among others.[6,7]

Some studies have already moderated that, although little investigated, they are common as sexual dysfunctions in young women[8] and university women[9], but there are still limitations in them, mainly because they are local studies with data that may not be representative for other regions.

In this sense, this study aims to investigate sexual dysfunction in young university women in a public university in the capital of Bahia and what factors are associated with it to contribute to science through the information that is representative of this population.

Method

This is an observational, cross-sectional analytical study carried out in the pavilions of the physiotherapy course at the Unviersidade Federal da Bahia (UFBA), in Salvador, Bahia, Brazil, between September and October 2019. Female university students, aged between 18 and 35 years of all semesters of the undergraduate course in Physiotherapy at UFBA participated in the study, who were in at least one heterosexual relationship in the last 6 (six) months and who agreed to participate by reading, understanding and signing the Free, Prior and Informed Consent (FPIC).

For this study, a convenience sample was used; therefore, a sample calculation was performed to estimate the proportion of young women with sexual dysfunction. The confidence level used was 95%, the acceptable difference was 0.05, the sexual dysfunction proportion was 36%[9], and the population estimated 250 students in the physiotherapy course. The recommended sample for the study was 147 participants. The estimated sample was not reached since the volunteers who agreed to participate in the study and who met the eligibility criteria totaled 116 participants.

Collection procedures

In order to recruit participants, the research was disseminated in person in classrooms of the UFBA physiotherapy course. All participants who met the eligibility criteria and agreed to participate, read, understood, and signed the FPIC under the terms of the survey, received, individually, an envelope without identification containing the evaluation questionnaires: "Investigation of associated factors" developed by the researchers and "Sexual quotient - Female version (SQF)." The participants answered the questionnaires individually, and the time required for each one was respected.

After completing the questionnaire, it was returned in the envelope. The names of the participants were not asked at any time during the research, except in the FPIC, which was collected separately from the envelopes, to reduce the risk of identifying the participants.

The primary outcome was the QSF score, as possible associated factors (predictors), the variable evacuation effort, low evacuation frequency, urinary urgency, urinary incontinence, urinary loss on exertion, sexual, urinary loss, and violence and as possible confounders, age, and the marital status.

Collection instruments

The first questionnaire called "Investigation of associated factors" was developed by the researchers in order to investigate the sociodemographic data (age and marital status), sexual history (frequency), history of pelvic floor dysfunction (effort and frequency of evacuation, urinary symptoms), obstetric history (number and route of delivery, episiotomy, abortion), gynecological, neurological, hormonal conditions, use of contraceptive medication and history of violence (Appendix A).

Furthermore, the second is a validated questionnaire "Sexual quotient - Female version (SQ-F)".[10] It has ten questions, which vary on a Likert scale of 0-5, in which 0 corresponds to never and 5 to always. In terms of the total score (0-100), the SQ-F assesses the general quality of the woman's sexual performance/ satisfaction.

This instrument can also identify in which aspects of the sexual response the woman has difficulty. Low scores for questions 1, 2, and 8 mean little sexual desire. Questions 3, 4, 5, and 6 assess different aspects of the female arousal phase. A high score for question 7 confirms the presence of pain in the relationship. Difficulty with orgasm and little or no satisfaction with sex is evidenced by low scores for questions 9 and 10.

Thus, in this study, we considered the division into four categories for analysis, namely: desire/interest, female arousal, pain, and orgasm/satisfaction.

Statistical analysis

A descriptive statistical analysis was performed. Categorical variables were summarized in absolute and relative measures. Quantitative variables were presented as means and standard deviations. Statistical inference was performed using the T-Student test, which compared the independent variables. A significance level of 5% was adopted. The data were analyzed using the Statistical Package for the Social Sciences (SPSS) version 22 software.

Ethical aspects

The present study respects the ethical aspects of research involving human beings in resolution CNS 466/12, treating the subjects in their full dignity, respecting their autonomy, guaranteeing data confidentiality and justice. The research project was submitted and approved by the Research Ethics Committee of the Health Sciences Institute - Federal University of Bahia, under opinion 3,547,537.

Results

During the collection period, 116 women were interviewed. From the data collected, participants who did not complete the partial or complete questionnaire "Sexual quotient - Female version (SQ-F)" were used as an exclusion criterion, adding five losses for this reason. One hundred eleven participants were considered for analysis purposes. However, incomplete "Investigation of associated factors" questionnaires were included, as shown in Table 1. The average age of the population was 23 years old, most of them single (n= 101, 91,8%), with sexual relations frequency from once to twice a week (n= 43, 38,7%). Only 5.6% (n=6) of the population became pregnant and, of these, 2,7% (n=3) progressed to abortion. As for the investigated health conditions, the most frequent occurrence was gynecological conditions (n= 33, 30%), with ovarian cysts being the most common alteration (n= 16, 48,4%), followed by endometriosis (n= 7, 21,21%), recurrent urinary infection (n= 6, 18,18%) and fibroids and other conditions (12.12% each). The majority of the population (n= 65, 58,6%) uses some contraceptive medication, with oral contraceptives being the most common type (n= 55, 84,6%). 23,4% (n=26) have already suffered some violence, most of which (n= 17, 65,4%) were of the psychological type Table 1.

When asked about the diagnosis of pelvic floor dysfunction (PFD), only one participant acknowledged the diagnosis. However, when investigated, the occurrence of symptoms of PFD was frequent. Regarding the symptoms of intestinal constipation, 30,28% (n= 33) of perception of low evacuation frequency and 26,36% (n= 29) of evacuation effort were found. Regarding urinary symptoms, 15,6% (n= 17) reported urinary urgency, 11% (n= 12) urinary loss on exertion and, less frequently, urinary loss during sexual intercourse (n= 5, 4,72%) and urge incontinence (n= 5, 4,63%).

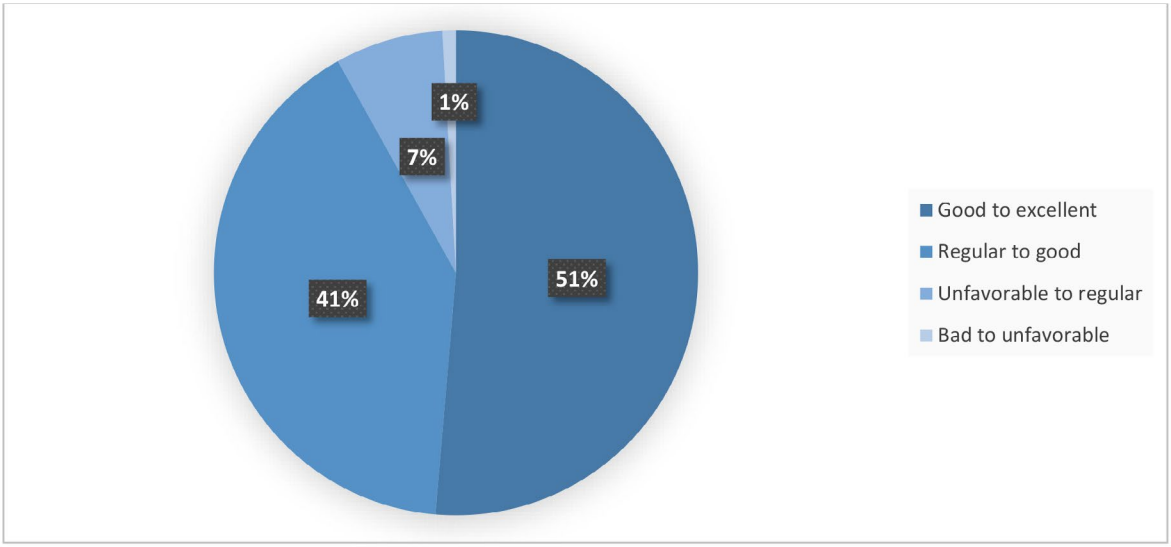
Table 1. Sample's characterization of university women regarding socio-demographic, gynecological, obstetric and other health conditions

Variables (n)	Mean (DP)	n(%)
Age (111)	23,25 (3,50)	
Civil status (110)*		
Single		101(91,8%)
Married		6(5,5%)
Divorced		2(1,8%)
Other		1(0,9%)
Sexual frequency (111)		
More than 3 times/week		13(11,7%)
1 a 2 times/week		43 (38,7%)
1 a 3 times/month		33(29,7%)
Less than 1 time/month		22(19,8%)
Pregancy (107)*		6(5,6%)
Type of birth (107)*		
Vaginal		2(50%)
Cesarean		2(50%)
Abortion (110)*		3(2,7%)
Episiotomy (110)*		0
Evacuation effort (110)*		29(26,4%)
Low evacuation frequency (109)*		33(30,3%)
Urinary urgency (109)*		17(15,6%)
Urge-Urinary incontinence (109)*		5(4,6%)
Urinary loss on exertion (109)*		12(11%)
Sexual urinary loss (106)*		5(4,7%)
Gynecological condition (110)*		33(30%)
Neurological condition (111)		4(3,6%)
Hormonal condition (110)*		12(10,9%)
Use of contraceptive medication (111)		65(58,6%)
Violence (111)		26(23,4%)
Type of violence (26)		
Physical		4(15,4%)
Sexual		5(19,2%)
Psychological		17(65,4%)

* There were data losses for these variables

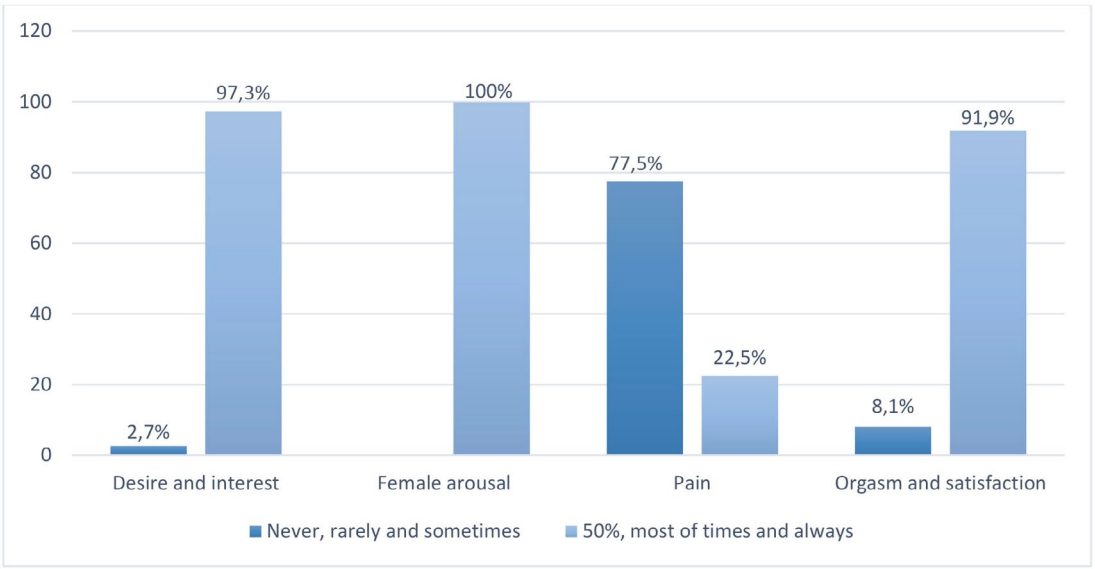
As for sexual performance/satisfaction obtained through the SQ-F score (0-100 points), the majority of the population had adequate sexual function with a good to excellent (82-100 points) and regular to the good concept (62-80 points). This study found a prevalence of 8% (n=9) of SD, established as a cutoff point for screening SD scores below 60 points. No null to bad concept (0-20) was found in any participant Fig. 1.

Figure 1. Percentage distribution based on the concept obtained through the total SQ-F score



With the data found in the SQ-F, through the grouping of questions, it is still possible to distinguish which aspects of the sexual response the difficulties of the participants are. Considering that the answers to the questionnaire vary on a Likert scale of 0-5, for analysis, we have grouped the answers into two sets: those ranging from 0 to 2 classified as “never, rarely and sometimes” and the answers between 3 and 5, considered as “50%, most of the time and always”, since the first set “never, rarely and sometimes” indicates a tendency to SD for all aspects, except for the “pain” category in which this maxim is inverted. Thus, through the sets of responses analysis, it is observed that 22.5% of the population tends to have SD related to pain, 8.1% to orgasm and satisfaction, and 2.7% to desire and interest. Fig. 2.

Figure 2. Percentage distribution of SD tendency in the sample of university women, based on the categorization of the SQ-F in domains and separated into sets of 0 to 2 (never, rarely and sometimes) and 3 to 5 (50%, most of times and always)



By correlating the average of the total SQ-F score with the occurrence or not of the investigated associated factors, it was possible to identify that, for most categories, presenting an associated factor (PFD symptoms or violence) is related to a lower total score, indicating worse sexual performance/satisfaction compared to participants who do not have these factors. This difference was statistically significant for the occurrence of the evacuation effort symptom. The same did not apply to the variable urinary loss during sexual intercourse in which presenting this symptom resulted in a higher total score on the SQ-F. Table 2.

Table 2. Correlation between investigated associated factors and mean in the total SQ-F score in university women (p value referring to Student's T test)

ASSOCIATED FACTORS	Mean (DP)	p
Evacuation effort		
No	81,70(10,34)	
Yes	76,62(13,18)	0,03
Low evacuation frequency		
No	80,97(11,08)	
Yes	78,91(12,06)	0,38
Urinary urgency		
No	81,13(10,42)	
Yes	76,12(15,22)	0,09
Urge-Urinary incontinence		
No	80,43(11,39)	
Yes	79,20(12,05)	0,81
Urinary loss on exertion		
No	80,39(11,40)	
Yes	79,83(11,55)	0,87
Sexual urinary loss		
No	80,46(10,28)	
Yes	86,40(15,96)	0,22
Violence		
No	81,34(11,52)	
Yes	77,46(10,12)	0,12

* There were data losses for these variables

When comparing the occurrence or not of factors associated with each domain assessed by the SQ-F, statistically significant correlations were found between evacuation effort and less female arousal (p = 0.01); evacuation effort and more pain (p = 0.04); urinary urgency and more pain (p = 0.04); in addition to violence and worse arousal (p = 0.05); and violence and less orgasm/satisfaction (p = 0.02)

However, it was also possible to observe a higher mean in the domain orgasm and satisfaction in individuals who reported urge-incontinence, a higher mean in the domain desire/interest and female arousal in those who present urinary loss on efforts and also indicative means of better performance/satisfaction in all domains in women who present urinary loss during intercourse. Table 3.

Table 3. Correlation between investigated associated factors and mean by domain of the SQ-F in university women (p value referring to Student's T test)

	Desire e interest		**Female arousal**		**Pain**		**Orgasm and satisfaction**	
	Mean(±DP)	p	Mean (±DP)	p	Mean (±DP)	p	Mean (±DP)	p
Evacuation effort (110)*								
No	11,51(2,06)		17,98(1,92)		1,49(1,43)		7,83(1,79)	
Yes	11,44(2,41)	0,88	16,82(2,64)	0,01	2,13(1,59)	0,04	7,17(1,81)	0,08
Low evacuation frequency (109)*								
No	11,52(2,16)		17,77(2,12)		1,60(1,44)		7,78(1,75)	
Yes	11,45(2,19)	0,87	17,45(2,37)	0,48	1,84(1,62)	0,43	7,39(1,96)	0,3
Urinary urgency (109)*								
No	11,63(1,03)		17,78(2,06)		1,55(1,40)		7,70(1,72)	
Yes	10,82(2,74)	0,15	17,11(2,78)	0,25	2,35(1,80)	0,04	7,47(2,32)	0,62
Urge-urinary incontinence (109)*								
No	11,54(2,12)		17,67(2,21)		1,62(1,45)		7,61(1,84)	
Yes	11,0(3,0)	0,58	17,60(2,30)	0,93	2,80(2,16)	0,08	8,80(0,44)	0,15
Urinary loss on exertion (109)*								
No	11,46(2,12)		17,65(2,25)		1,61(1,44)		7,69(1,81)	
Yes	11,83(2,51)	0,57	17,83(1,69)	0,79	2,08(1,92)	0,31	7,33(1,92)	0,52
Sexual urinary loss (106)*								
No	11,50(2,01)		17,72(2,04)		1,65(1,50)		7,65(1,76)	
Yes	12,60(2,60)	0,24	18,20(3,03)	0,62	1,40(1,51)	0,71	8,80(1,30)	0,15
Violence (109)*								
No	11,55(2,09)		17,91(2,19)		1,68(1,55)		7,88(1,73)	
Yes	11,42(2,38)	0,79	16,96(1,98)	0,05	1,61(1,29)	0,84	6,96(1,88)	0,02

* There were data losses for these variables

Discussion

The profile of university women found in this study is similar to another Brazilian study carried out with university nursing students with an average age of 23.4 years, majority single (92.2%) and low frequency of children (7.8%).[11] However, the results found based on the SQ-F concept are divergent. In the present study, sexual performance/satisfaction reached a "good to excellent" concept in 51% of the population. In the study by Fonseca[11], the same domain obtained this same concept in only 31.3% of the population. These authors[11], who also used the same criterion for the SD' proposed definition in the validation of the SQ-F, found a prevalence of 27.9%.

The prevalence of SD found in the present study, based on the total SQ-F score, also disagrees with other authors who used different assessment instruments to verify sexual function in Brazilian university students.[12,13] The study by Satak et al.[12], with female undergraduate health students, including physiotherapy, points to an SD frequency of 28.8% in the southeastern region. In contrast, Bezerra[13], who compares sexual function among and Brazilian undergraduate students in the Northeast region and Italian undergraduate students, shows that 38.1% of Brazilian women have SD, reinforcing the difference in prevalence in the country's same region.

This leads us to consider that the prevalence found in our study was low, diverging from the prevalence of SD for young Brazilian women, university students or not, using SQ-F or other assessment instruments. It is important to note that all the studies mentioned above presented a representative sample of the population and that the samples studied are similar in some aspect to the present study.

In the study by Abdo[5], women with a higher level of education (university) had a lower frequency of SD (desire, pain, and orgasm) when compared to women with a lower level of education. As our population was composed of women in university education, this can be pointed out as one factor for the reduced prevalence of SD.

When analyzing the type of SD, we found a higher frequency of pain-related dysfunction (22.5%), followed by orgasm/satisfaction (8.1%) and desire/interest (2.7%). Those results disagree with another Brazilian study regarding the most common type of dysfunction, which suggests that the most common SD in single women would be related to dissatisfaction (67.2%), orgasm (53.1%), pain (50%), and lubrication (45.3%).[14] This same study also proposes that single women have a worse sexual function, analyzed through the Female Sexual Function Index (FSFI), when compared to people involved in stable relationships[14], what differs from our study's results in which the population is mostly composed of single women who had a low frequency of SD.

Our results agree with the findings of the Brazilian Sexual Behavior Study (BSBS)[15], which demonstrates that, for the female population in general, the main SD is the absence of orgasm (29.3%) and lack of sexual desire (34.6%).

A review of lower urinary tract symptoms and sexuality addresses a study carried out with incontinent women that found that 46% of patients negatively affected sexual life.[6] These findings, therefore, differ from those found in the present study since the averages for the participants with urinary loss during sexual intercourse pointed to better sexual performance/satisfaction in all domains.

This study found statistically significant results for the relationship between evacuation effort and worse sexual performance/satisfaction. In addition, this symptom is also specifically associated with impairment in the arousal and pain domains. A recent review[16] investigating the effect of fecal incontinence and constipation on sexual function points to a scarcity of quality studies on the subject but still presents a study with women receiving treatment for PFD, including constipation. This study shows a positive correlation between women of childbearing age with increased pelvic floor muscles (PFM) tone and worse sexual function, agreeing with our findings for constipation and worse sexual function. They also argue that different types of constipation can have different effects on sexual function[16], which agrees with our study since we found statistical significance in the association of worse sexual function with evacuation effort, but not with low evacuation frequency.

We also found a positive relationship between experiencing urinary incontinence symptoms and pain during intercourse, in agreement with Su et al., who found urge urinary incontinence as a risk factor for decreased sexual lubrication and more sexual pain.[17] Another study[18], whose sample was older than the present study, shows that women with urge incontinence had lower scores for sexual function when compared to others without this symptom.

Another statistically relevant finding in our study points to the relationship between a history of violence and arousal and orgasm/satisfaction losses. Studies point to the relationship between suffering some violence and the subsequent manifestations associated with this event[19,20], considering violence as a history of trauma. Our results converge with those found in several studies, such as that by Faundes[20], who correlated sexual symptoms in women victims of some sexual violence (sex against will with and without embarrassment, rape). These authors found that women with this history had reduced libido, anorgasmia, and dyspareunia and that this percentage was higher for all categories as the violence became more explicit. Other studies associate the history of violence with dyspareunia.[19-21] This dysfunction is consistently associated with negative consequences, such as reduced sexual desire and arousal, lower sexual frequency, and psychological distress.[21]

Relevant data from this study indicate an association of SD and some symptoms of PFD (evacuation effort, low evacuation frequency, urinary loss of urgency, on exertion, and during sexual intercourse). However, regarding SD assessed through the total score of SQ-F about sexual performance/ satisfaction in the entire population, the prevalence found was low (8%) compared to other analyzed populations in the previous research.[8,11,12] These data can be justified by the level of education of the participants, the low frequency of risk factors in this population, and, perhaps, attributed to the profile of the undergraduate course under study. Considering that there are curricular elements about sexual activity and function from diagnosis to treatment in the physiotherapy course, this may be associated with a greater understanding of the sexual function and, consequently, lower rates of dysfunction.

The strengths of this research were to study women in a young age group and with a specific level of education, in addition to seeking an association with several risk factors. The weaknesses are attributed to the study being directed to students of only one course and institution, not to relate the participants' responses to the current semester, in addition to the absence of relevant sociodemographic data such as race/color and income.

As limitations of this study, the population did not reach the recommended in sample calculation, making it difficult to infer the data as representative of the population, and we reinforce the absence of assessment instruments that make it possible to investigate sexual function more broadly, with the capacity to include women with the last sexual intercourse date greater than six months and with sensitivity for homosexual women.

Conclusion

For the studied sample, we concluded that the prevalence of SD in young university women was low compared to previous research. Evacuation effort is associated with less overall sexual performance/ satisfaction and less excitement and more pain; urinary urgency is associated with more pain, and violence is associated with less excitement and orgasm. It is suggested that further studies be carried out from the perspective of sexual dysfunctions in young women, with collection instruments that are capable of evaluating aspects relevant to the sexual function cutting out active sex period or sexual orientation.

Authors 'contributions

Purification ER participated in the conception, design, search, and statistical analysis of the research data, interpretation of results, writing of the scientific article. Santos ASA participated in the conception, design, interpretation of results, writing of the scientific article, critical review, and approval of the final version to be published. Ferraz DD participated in the design, search, and statistical analysis of the research data, interpretation of the results, critical review, and approval of the final version to be published.

Competing interests

No financial, legal, or political competing interests with third parties (government, commercial, private foundation, etc.) were disclosed for any aspect of the submitted work (including but not limited to grants, data monitoring board, study design, manuscript preparation, statistical analysis, etc.).

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INVESTIGATION OF ASSOCIATED FACTORS

The questions must be followed with sincerity, since these results found for scientific purposes

Age _____

Civil Status

( ) Single ( ) Married ( ) Divorced ( ) Widow
( )Other Which _____

SEXUAL HISTORY

Have you participated in sexual intercourse in the last 6 (six) months?

Yes ( )

No ( )

How often do you participate in sexual intercourse?

_____ times a month

_____ times a week

( ) Does not perform

HISTORY OF PELVIC FLOOR DYSFUNCION

Do you have a diagnosis of any pelvic floor dysfunction?

Yes ( ) No ( )

Do you notice difficulty or effort to evacuate?

Yes ( ) No ( )

Do you notice that you evacuate infrequently?

Yes ( ) No ( )

Do you lose urine involuntarily on exertion or, when you have a desire to urinate, do you have to run to the bathroom?

Yes ( ) No ( )

Do you have or have you had urinary loss during intercourse?

Yes ( ) No ( )

Do you have recurrent urinary tract infection?

Yes ( ) No ( )

OBSTETRIC HISTORY

Have you got pregnant?

Yes ( ) How many times?_____

No ( )

Was an episiotomy performed?

Yes ( )

No ( )

Did you have an abortion?

Yes ( ) How many times?_____

No ( )

Type of delivery

( ) Vaginal How many?_____

( ) Cesarean How many?_____

OTHER CONDITIONS

Do you have any gynecological conditions? (Ex. Ovarian cysts, endometriosis, fibroids etc ...)

Yes ( ) How many times?_____

No ( )

Do you have any neurological changes? (Ex. Paraesthesia, paralysis, muscular dystrophy, slipped discs etc ...)

Yes ( ) How many times?_____

No ( )

Do you have any hormonal changes?

Yes ( ) How many times?_____

No ( )

Do you use any contraceptive medication?

Yes ( ) How many times?_____

No ( )

Have you suffered any kind of violence?

Yes ( ) No ( )

If yes:

( ) Physical (Any conduct that threatens your physical integrity)

( ) Sexual (Any type of sexually oriented activity not consented)

( ) Psychological (Any conduct that causes you emotional or psychological damage)

( ) Other _____