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Methods A casenote review was done on all new and rebook (attending again after 3 months or more for a new episode of care) patients who attended during the first week of September 2011. The history proforma included questions on DV, alcohol consumption, recreational drug use and if they felt this affected their risk taking. Asymptomatic patients for screening were excluded as no detailed history was taken.

Results The history proforma was filled out for 55 women and 22 men. All were heterosexuals. The median age was 25. 26 attended for contraception, 44 for sexual health screen and 7 for both. 21 were rebook patients. 58/55 (69%) women were asked about DV. Five gave a history of DV, four were historic, one unspecified. 63 (82%) and 62 (81%) were asked their alcohol and drug use respectively. One man disclosed drinking >21 units/week and that it affected his risk taking. 10 used drugs: six cannabis, one cocaine.

Five gave a history of DV, four were historic, one unspecified. Implications are that REA should be done in clinics and should be considered in men, perhaps using a self-completed questionnaire.

Discussion The relatively low rate of enquiry for DV may increase with training and awareness raising. Only one patient considered his risk taking affected by alcohol. This may be due to the lack of sensitivity of direct questioning. Closer working with supporting agencies for DV, alcohol and drug use may increase referrals.

Background Sexual violence (SV) is common but under-reported in the UK. Victims of SV may be more likely to attend genitourinary medicine (GUM) clinics but there are no recent urban data.

Aims To determine the prevalence and correlates of SV in female GUM attendees. To assess whether routine enquiry on SV is warranted and to gauge if specific SV resources are needed in GUM.

Methods Questionnaire-based survey offered to all women attending our two urban walk-in GUM clinics. Participants self-completed anonymous proformas about any experiences of SV using a broad definition of SV. Demographic, clinical and behavioural data were also collected.

Results Analysis of the initial 164 surveys showed a median age of 27 (IQR 23–31). Ethnicity was typical of the clinics’ populations: 62% UK born; 40% White British, 21% White other, 16% Black British, 5% Black African and 7% Black Caribbean. When asked about a history of SV ever, 17% responded yes; in 36% of these women SV had happened more than once. Median age at the time of SV was 19 years (range 6–40); 22/164 (13%) described the SV as rape/sexual assault and in two women this was in the last year. Only two women described their assailant as a stranger; one confirmed her SV was gang-related. Additional women responded to queries on forced oral sex 5%, forced touching 7%, forced sex without a condom 11%. Of 32 women who told someone it included a health professional in only 28% and the police in 25%. 78% of all participants agreed it was helpful to ask routinely about SV and 87% felt that a SV worker was needed in the clinic; four women indicated that their reason for attending GUM today was SV. Further study is warranted within GUM settings to establish if routine enquiry and SV service provision should be core business.

Discussion REA was acceptable to the majority. GBV history was not insignificant in men. This survey used a narrow definition of GBV and reports may have been higher had a more inclusive definition been used. Implications are that REA should be done in clinics and should be considered in men, perhaps using a self-completed questionnaire.