Planned Parenthood® of Illinois
18 S. Michigan Ave. 6th Floor Chicago, IL 60603
312.592.6800

# Male Medical History Form

| TODAY'S DATE: | PATIENT #: | DATE OF BIRTH: |
|---|---|---|
| NAME OF PATIENT: | | AGE: |

## Medical History

**Please check if YOU have had any of the following:**

❑Yes ❑No Stroke/Blood Clots
❑Yes ❑No Blood Transfusions
❑Yes ❑No Heart attack or chest pains
❑Yes ❑No Kidney problems
❑Yes ❑No Gallbladder Disease
❑Yes ❑No Diabetes
❑Yes ❑No Seizures
❑Yes ❑No High cholesterol
❑Yes ❑No Cancer (Type:_____)
❑Yes ❑No Urological Conditions

❑Yes ❑No Alcohol Use
❑Yes ❑No Drug Use
❑Yes ❑No Migraines
❑Yes ❑No Breast cancer or lumps in your breast
❑Yes ❑No Liver tumor or disease
❑Yes ❑No Severe long term depression
❑Yes ❑No Eating Disorder (anorexia, bulimia)
❑Yes ❑No High blood pressure
❑ Other: _____

Do you smoke? ❑Yes ❑No If Yes, how much? _____

Do you have any allergies? ❑Yes ❑No If yes, explain: _____

Are you currently taking any medications? ❑Yes ❑No Type: _____

Please circle if you have had the following immunizations: Rubella (MMR) Tetanus Hepatitis B

Have you been hospitalized? ❑Yes ❑No If yes, for what: _____

Do you / have you had any significant illnesses or major surgeries? ❑Yes ❑No If yes, explain: _____

## Social/Sexual History

Age at first intercourse? _____ How many children have you fathered? _____
How many sexual partners do you have now? _____, in your lifetime: _____
Is/Are your partner(s) ❑ male ❑ female ❑ both
Check type(s) of sex you have: ❑ Vaginal ❑ Oral ❑ Anal ❑ Outercourse ❑ Other _____
Do you use condoms? ❑ Always ❑ Never ❑ Sometimes
Have you, or any of your past or current partners, had any of the following infections: ❑ Chlamydia ❑ HIV ❑ Trich
❑ HPV/Genital Warts ❑ Hepatitis (A, B, or C) ❑ Syphilis ❑ Herpes ❑ Gonorrhea ❑ Nongonocchocal Urethritis (NGU)
Date(s):_____

Do/have any of your past or current partners: (circle) Use IV drugs Been Incarcerated Males having sex with males
Have multiple partners

Do you have any concerns/problems related to abuse, violence or assault? ❑Yes ❑No

## Family History

❑ I am adopted (skip this section if you do not know biological family medical history)
Has anyone in your **immediate family** ever had the following? If yes, indicate father (F), mother (M), brother (B), sister (S)

Diabetes _____
High Cholesterol _____
Heart Attack/ Surgery _____
Testicular Cancer _____

Mental Health _____
Stroke _____
High Blood Pressure _____
Prostate Cancer _____

**Patient Signature: _____ Date: _____**

Reviewed by: _____ Date:_____

Reviewed by: _____ Date:_____

Reviewed by: _____ Date:_____