

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

Medical History

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

- | | | | |
|--|-----------------------------|--|---------------------------------------|
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Stroke | <input type="checkbox"/> Yes <input type="checkbox"/> No | Alcohol Use |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Blood clots | <input type="checkbox"/> Yes <input type="checkbox"/> No | Drug Use |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart attack or chest pains | <input type="checkbox"/> Yes <input type="checkbox"/> No | Migraines |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney problems | <input type="checkbox"/> Yes <input type="checkbox"/> No | Breast cancer or lumps in your breast |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Gallbladder Disease | <input type="checkbox"/> Yes <input type="checkbox"/> No | Liver tumor or disease |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Diabetes | <input type="checkbox"/> Yes <input type="checkbox"/> No | Severe long term depression |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Seizures | <input type="checkbox"/> Yes <input type="checkbox"/> No | Eating Disorder (anorexia, bulimia) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | High cholesterol | <input type="checkbox"/> Yes <input type="checkbox"/> No | High blood pressure |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | Cancer (Type: _____) | <input type="checkbox"/> Other: _____ | |

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

Do you have any allergies to medications? Yes No If yes, explain:

Social/Sexual History

Age at first intercourse? _____

How many sexual partners do you have now? _____, in your lifetime: 0 1 2-5 more than 5

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 had any of the following infections: Chlamydia HPV/Genital Warts HIV Hepatitis (A, B, or C)
 Trich Syphilis Herpes (HSV) Gonorrhea Nongonococcal Urethritis (NGU)

Date(s): _____

Do you have any concerns/problems related to abuse, violence or assault, which you would like to discuss? 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 _____

Mental Health _____

High Cholesterol _____

Stroke _____

Heart Attack/Surgery _____

High Blood Pressure _____

Testicular Cancer _____

Prostate Cancer _____

Patient Signature: _____ **Date:** _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____

Reviewed by: _____ Date: _____