

## 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:

- |  |  |
|--|--|
| <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: \_\_\_\_\_

Are you currently taking any medications?  Yes  No If yes, type: \_\_\_\_\_

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

Have you had a blood transfusion?  Yes  No

### 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: \_\_\_\_\_